Child Intake Form Therapeutic Services 4 Children and Families

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Child's Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

____
(Last) (First) (Middle Initial)

Child's Birth Date: ______ /______ /______ Age: ________ Gender: □ Male □ Female

Parents Marital Status:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

Please list all siblings/age: ____

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: ____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____

May we thank the referral source? □ Yes □ No

Has your child ever received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: ____

Is your child currently taking any prescription medication?
□ Yes
□ No

Please list: ____

____

Has your child ever been prescribed psychiatric medication?
□ Yes
□ No

Please list and provide dates: ____

____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems your child is currently experiencing:

____

2. How would you rate your child's current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems your child is currently experiencing:

____

3. How many times per week does your child generally exercise? __________

What types of exercise do they participate in _________________________________

4. Please list any difficulties your child has with his or her appetite or eating patterns

____

5. Is your child currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? ________________________

6. Is your child currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did they begin experiencing this? ___________________________

7. Is your child currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe ___________________________

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? __________________

On a scale of 1-10, how would you rate your relationship with your child? __________

11. What significant life changes or stressful events has your child experienced recently?

____

FAMILY MENTAL HEALTH HISTORY:
In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Does your child attend school? □ No □ Yes

If yes, what grade level and school do they attend:

____

Does your child enjoy school? Is there anything stressful about their school? *Low grades, peer relations etc.*

____

____

2. Do you consider your family to be spiritual or religious? □ No   □ Yes

If yes, describe your faith or belief:

____

3. What do you consider to be some of your child's strengths?

____

____

____

____

4. What do you consider to be some of your child's weakness?

____

____

____

____

5. What would you like your child to accomplish out of their time in therapy?

____

____

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