CHILD & ADOLESCENT INTAKE FORM

Today's Date: _____

Name: _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

School:_____ Grade:_____

Mother/Guardian
Name: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ 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.

Father/Guardian
Name: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ Cell/Other Phone: _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

Siblings
Please list any siblings/age: _____

Referred by: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Please list any specific health problems child/adolescent is currently experiencing:

Has child/adolescent previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes

If yes, previous therapist/practitioner: _____

Please list any prescription medications and dosage that child/adolescent is currently taking:

Name of Prescribing Physician:_____

Has child ever been prescribed psychiatric medication? □ Yes □ No
If yes, please list and provide dates:

Please list any specific sleep problems child is currently experiencing:

What types of exercise does child participate in?

Please list any difficulties with appetite or eating patterns:

Is child currently experiencing overwhelming sadness, grief or depression? □ No □ Yes
If yes, for approximately how long? _____

Is child currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes
If yes, when did child begin experiencing this? _____

Does child/adolescent drink alcohol or engage in recreational drug use?

Please list any legal issues that may be in progress:

Any complications with pregnancy or delivery?

Did child meet developmental milestones as expected?

Has child been diagnosed with any learning disabilities?

Is there anything stressful about school?

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

What goals do you have for therapy?

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 you 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	