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Child/Minor Intake Form

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.

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

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

Marital Status of Parents:
□ Never Married □ Domestic Partnership □ Married/date □ Separated/date

□ Divorced/date □ Widowed/date

Father's name_____DOB_____
Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Father's place of employment_____

_____

Mother's name_____DOB_____

Address (if different from above:
_____
(Street and Number)
_____
(City) (State) (Zip)

Mother's place of employment_____

_____

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

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

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

*Please note: Email correspondence is not considered to be a confidential medium of communication.
Referred by (if any): _____

Child's school/address/teacher's name/phone_____

_____

Is your child in special education? Yes/No, If yes what kind of program?_____

Is your child adopted? Yes/No, If yes, age when adopted_____

Child's primary doctor_____Phone_____
Address_____Fax_____

Please list any other physicians who regularly care for your child_____
_____
(If you would like information shared with anyone listed above (doctors, school, teachers) please fill out a release form)

Please list any other children/age: _____

Please list any other family members you live with or that are significant to you in regards to this therapy work:_____
_____

What significant life changes or stressful events have you (or your family) experienced recently:
_____
_____

Please list any spiritual beliefs and/or cultural values that are important to you and your family, which may help guide and inform our work together:
_____
_____
_____

MENTAL HEALTH

1. Has you child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner, date and place:_____
_____

2. If there has been previous hospitalization or inpatient or outpatient psychiatric services, please list the dates, places and attending physician:_____

_____

3. Is your child *currently* taking any prescription/psychiatric medication?
□ No
□ Yes - Please list: _____
_____

4. Has your child *ever* been prescribed psychiatric medication?
□ No
□ Yes - Please list psychiatric medication and provide dates:
_____
_____

GENERAL HEALTH INFORMATION

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

Poor Unsatisfactory Satisfactory Good Very good

2. Please list any specific health or medical issues your child is *currently* experiencing:
_____

3. Please list any prescription medication that your child is currently taking:
_____
_____

4. Please describe any serious present or past medical conditions, surgeries, head injuries, hospitalizations or accidents your child has experienced and at what age:
_____
_____
_____

5. Does your child have a history of alcohol or substance use? □ No □ Yes

6. If you answered yes to the previous question please list type and any previous substance abuse treatment, dates and place:_____

_____

7. Please list any consequences of their substance use (i.e.: vocational, academic, relational, legal, medical):_____

_____

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	
Attention Hyperactive/Deficit Disorder	yes/no	
Anxiety	yes/no	
Bipolar	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Fibromyalgia	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Please list any other known health conditions within your family (ie. High blood pressure, cancer, kidney disease, heart conditions, etc): _____

_____

CURENT FUNCTIONING/STRENGTHS:

What are your child's interests, hobbies, extra-curricular activities? _____
_____

What are your child's strengths? _____
_____

Please rate your child by stating "Above average, Average, or Below average" on the items below, and any other descriptors that may apply:

Gross motor skills (i.e. Running, throwing)_____
Fine motor skills (i.e. Writing, cutting)_____
Attention_____
Impulse control _____
Academic skills_____
Expressive language (speaking)_____
Receptive language (listening, understanding)_____
Social skills_____
Aggression_____
Emotional control_____
Eating habits_____
Sleep habits_____
Other areas you observe difficulties:_____
_____

NEEDS

What are your chief concerns regarding your child? _____
_____

What are your child's main concerns? _____
_____

Please list your goals for your child's treatment:_____
_____

What are your child's goals? _____
_____

This information provided by:

_____ _____
Signature and relationship to child Date

Reviewed in initial interview by:

_____ _____
Signature Date

Please bring copies of any documents to your initial interview (i.e. school reports, previous psychological evaluations, IEP's, etc) that would help me get to know your child better.