Child Intake

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Date:_____ Referred by:_____

Client Name: _____
(first) (middle initial) (last)

Date of Birth: ____/_____/_____ Age: _____ Gender: M F

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Email: _____

School: _____Grade_____

Custody status: _____

Name of Parents_____ Phone_____
_____Phone_____

If planning to use health insurance: Name of insurance company
_____ Policy number _____ ID #_____ Name of Insured _____DOB_____
Address_____Phone_____

_____

Areas of Concern What issues/concerns causes you to seek treatment for your child? Please describe.
_____
_____
_____ Do you have any specific goals with regard to your child's
treatment?_____
_____
_____
_____

Psychological History Has your child ever received mental health treatment before? Yes No
When and for how long? _____ What was the focus of treatment? _____ Name of treating therapist(s), address(es), telephone number(s) _____
_____ Please Note: authorization for release of confidential information will be needed so that any former therapist may be contacted. Have you ever been hospitalized for mental or emotional problems? Yes No

When and for how long? _____ Why were you hospitalized? _____ Name of treating therapist, address, telephone number _____

Please list medications your child is currently taking _____ Prescribed by whom? _____ How long has your child been on the medications_____ Has your child ever taken any medications for a mental or emotional condition? Yes No When and for how long? _____

Please Note: authorization for release of confidential information will be needed so that health care provider may be contacted. Has your child ever attempted suicide? Yes No When? _____

Is your child currently having any suicidal thoughts? Yes No Please describe _____
_____
_____

Please describe your child's childhood Has your child ever been subjected to verbal, physical, emotional, sexual abuse? Yes No
Please describe. _____
_____
_____ Has your child ever been a victim of a violent crime? Yes No Please describe _____
_____
_____

Medical History Has your child ever been diagnosed with a serious illness? Yes No Please describe_____
_____
_____
_____

PLEASE THIS SECTION LEAVE BLANK Do you smoke? Yes No How much? _____ For how long? _____ Do you drink alcohol? _____ On average, how much alcohol do you consume in a week? _____ Do you currently use illegal drugs? Yes No Please describe your use _____
_____ Have you ever used illegal drugs? Please describe. _____
_____

Family of Origin History:

Mother's name, age, living/deceased, patient's age at the time of mother's death, description of relationship with mother. _____

_____

_____

Father's name, age, living/deceased, patient's age at the time of father's death, description of relationship with father. _____ Names and ages of siblings.

_____

Other Information:

Please describe your child's spiritual identity/orientation. _____

Please describe your child's interests/hobbies _____

Please feel free to include any other information that you believe is relevant to your child's mental health treatment, not previously mentioned. (i.e.) IEP, social relationships, developmental history, complications at birth, trauma, divorce, grief/loss, nightmares, behavior issues, or family history of mental health issues.

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