INTAKE FORM

Name of Child:_____Date:_____

Birth Date:_____ School:_____

Grade: _____ Teacher:_____

Home Address: _____
Street City Zip Code

Name of Parent:_____ Occupation:_____

Home Address_____

Home Phone #:_____ Work Phone #:_____

Cell Phone #:_____ E-mail:_____

Name of Parent:_____ Occupation:_____

Home Address: _____

Home Phone #:_____ Work Phone #:_____

Cell Phone #:_____ Email:_____

Why are you seeking therapy for your child at this time?

_____

_____

In case of emergency, Contact:

_____

Name Relationship

_____

Address Phone Number

Physician:_____ Phone #:_____

Has your child received any kind of mental health services before? If yes, describe:

Type_____

_____

Previous Clinician/Agency:_____

Dates: _____

Check any symptoms you have exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Insomnia
___ Excessive Sleep
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Overeating/binging
___ Eating disorder
___ Sexual Dysfunction
___ Lethargy
___ Long Periods of Elation
___ Suicidal Thoughts/Statements
___ Other (please describe):

___Nervousness/Jittery
___Irritable
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Excessive Nightmares
___ Self Mutilation

___ Substance abuse
___ Panic Attacks
___ Intrusive Thoughts

___ Excessive Fears

_____

_____

List/describe any history of emotional disorder(s) in your biological family:

List/describe any significant life events (e.g. divorce, death in family, etc.):

List/describe any current or historical physical concerns:

List/describe any drug and/or alcohol use:

List any medication(s) and dosage you are currently prescribed:

Please describe reason for seeking therapy

Please describe your goals and desired outcome for therapy:

_____

_____

Who referred you: