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Child/Teen Intake Form (For Parent/Guardian)

Client Information

Today's Date: _____ Referred by: _____

Child's Name: _____ Age: _____

Date of Birth _____ Grade: _____ Does the child attend church? Yes No

Child's Custodian/Guardian is/are: _____

Child's Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone #2: _____

Email Address: _____

Child lives with: Bio-Mom and Dad Bio-Mom only Bio-Father only Adoptive Parent(s)

Bio-Mom & Step Parent/Boyfriend/Other Bio-Father & Step Parent/Girlfriend/Other

Foster Care Provider Other: _____

Legal Custody is with: _____

Father's Information

Father's Name: _____ Age: _____

Father's Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____

Employer: _____

Father's Marital Status: Married Engaged Widowed Divorced Separated

Live with Partner Other: _____

Mother's Information

Mother's Name: _____ Age: _____

Mother's Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____

Employer: _____

Mother's Marital Status: Married Engaged Widowed Divorced Separated

Live with Partner Other: _____

Family Composition

Who currently resides in the same house as the child? Please include EVERYONE including any half or step siblings. Please indicate their full name, age and relationship to the child.

Name	Age	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____

Client's Medical and Personal Information

Has your child had counseling before? Yes No When? _____

Counselor/Therapist Name: _____

Agency's Name: _____

Agency's Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone: _____ Fax Phone: _____

Outcome: _____

Diagnosis: _____

Date of last medical exam: _____

Please rate your child's health: Excellent Good Average Poor

Has your child ever been hospitalized? Yes No If so, please explain below.

Is your child on medication? Yes No If so, please provide the following information.

Name of Drug	Dosage	For what?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Does your child have an addiction? Yes No Uncertain If so, please explain below.

Has your child had any previous trauma? Yes No Uncertain If so, please indicate what kind:

Physical Emotional Sexual Abortion Witness to crime Victim of crime

Has your child ever been arrested? Yes No If so, for

Basic Information

What concern has caused you to bring your child in for counseling at this time?

What has been done about your concern up to this present time?

Has anyone in the family experienced similar problems?

What is your assessment of the child's personality? Strengths, weaknesses, etc.

How would your child describe the problem?

What is the current family situation?

How do the parents relate to each other?

What is the parent's style of discipline?

What are your expectations for this child?

How is the child different from other members of the family?

How does the child handle stress?

Is there any other information you think we should know about?

Basic Information

- | | | |
|---|---|--|
| <input type="checkbox"/> Death of Parent(s) | <input type="checkbox"/> Trouble with in-laws | <input type="checkbox"/> Change in recreational habits |
| <input type="checkbox"/> Divorce of Parents | <input type="checkbox"/> Parent begins or ends work | <input type="checkbox"/> Change in Social Activities |
| <input type="checkbox"/> Separation of Parents | <input type="checkbox"/> Jail term | <input type="checkbox"/> Change in Sleeping Habits |
| <input type="checkbox"/> Remarriage of Parents | <input type="checkbox"/> Starting or finishing school | <input type="checkbox"/> Brother/Sister leaving home |
| <input type="checkbox"/> Death of close family member | <input type="checkbox"/> Change in living conditions | <input type="checkbox"/> Change in eating habits |
| <input type="checkbox"/> Personal injury or illness | <input type="checkbox"/> Revision of personal habits | <input type="checkbox"/> Vacation |
| <input type="checkbox"/> Fired from work | <input type="checkbox"/> Change of residence | <input type="checkbox"/> Christmas season |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Change in schools | <input type="checkbox"/> Minor violation with the law |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Addition to the family | <input type="checkbox"/> Death of close friend |
| <input type="checkbox"/> Change in work responsibilities | | |
| <input type="checkbox"/> Change in parents work hours, conditions | <input type="checkbox"/> Foreclosure of parent's mortgage or loan | |
| <input type="checkbox"/> Change of financial status of parents | <input type="checkbox"/> Change in family member's health | |
| <input type="checkbox"/> Outstanding work achievement | <input type="checkbox"/> Change in number of family gatherings | |

Other _____