PSYCHOLOGICAL SERVICES

CHILD THERAPY INTAKE FORM

Child Information

Child's Full Name: ______________________________

Date of Birth: ________________ Age: ________________

Gender/Pronouns: ______________________________

School: ________________ Grade: ________________

Home Address: ______________________________

Parent/Guardian Information

Parent/Guardian Name: ______________________________

Relationship to Child: ______________________________

Phone Number: ______________________________

Email Address: ______________________________

Preferred Method of Contact: ☐ Phone ☐ Email

Emergency Contact Name: ______________________________

Emergency Contact Phone: ______________________________

Referral Information

How did you hear about our practice?

☐ Physician
☐ Friend/Family
☐ Online Search
☐ Other: ______________________________
☐ School
☐ Insurance Directory

Who referred your child? ______________________________

Presenting Concerns

What concerns bring your child to therapy?

____

____

When did these concerns begin?

____

What symptoms or behaviors have you noticed?

☐ Anxiety
☐ Eating Difficulties
☐ Anger/Outbursts
☐ Social Difficulties
☐ Attention/Focus Issues
☐ Trauma/Stress
☐ Academic Stress
☐ Obsessive Thoughts or Compulsive Behaviors
☐ Sadness/Depression
☐ Difficulty at School
☐ Sleep Problems
☐ Behavioral Problems
☐ Grief/Loss
☐ Other: ____

Family & Home Information

Who lives in the home with the child?

____

Describe the child’s relationship with family members:

____

____

Any recent family changes or stressors?

☐ Divorce/Separation
☐ Death/Loss
☐ Illness
☐ Move
☐ New School
☐ Other: ____

Developmental History

Pregnancy/Birth Complications? ☐ No ☐ Yes

If yes, please explain: ______________________________

Developmental milestones reached on time?

☐ Walking ☐ Talking ☐ Toilet Training

Any concerns about development?

____

Medical History

Primary Care Physician: ______________________________

Physician Phone Number: ______________________________

Current Medications:

____

Allergies: ______________________________

Past Medical Conditions/Surgeries:

____

____

Has your child previously received counseling or psychiatric services? ☐ No ☐ Yes

If yes, please explain: ______________________________

School & Social Functioning

How is your child performing academically?

____

Any 504 or IEP? ☐ Yes ☐ No

Any behavioral concerns at school?

____

Does your child have friends or social supports?

____

Strengths & Interests

What are your child's strengths?

____

____

What activities does your child enjoy?

____

____

Goals for Therapy

What would you like your child to gain from therapy?

____

____

Consent & Signature

I certify that the information provided is accurate to the best of my knowledge.

Parent/Guardian Signature: ______________________________

Date: ______________________________