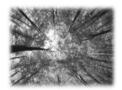


Smíth & Assocíates Mental Health

Child/Adolescent Intake Form

Name of Child:	Age: Birth Date:	Gender:
Parent/Guardian Name:		
Street Address:		
City: State:	Zip Code:	_
Phone Numbers: Home: Work:	Cell:	
Child's School/Daycare:	School Phone #:	
Grade: Teacher:		
Please list any medications your child is currently taking, inc	cluding psychotropic medications:	
Please describe any medical conditions or your child I should		
Please describe your current household composition (names,		child):
The reason I am seeking therapy for my child is:		
What have you already tried to correct or resolve this problem		
What are you most concerned about?		
What changes would you like to see as a result of therapy?		



Smith & Associates Mental Health

History

Is your child adopted?	yes	no
Has your child ever been or is he/she currently in foster care?	yes	no
Explain:		
Has your child received any previous counseling or treatment?	yes	no
Explain:		
Were there any problems or complications during pregnancy or birth?	yes	no
Explain:		
Has your child experienced any form of abuse (physical, emotional, sexual)?	yes	no
Explain:		
Has your child experienced any significant trauma or losses?	yes	no
Explain:		
Has your child experienced any divorces or separations?	yes	no
Explain:		
Does your child have difficulty at school or daycare?	yes	no
Explain:		
Does your child generally get along with other children his/her own age?	yes	no
Does your child generally get along with adults?	yes	no
Does your child have unusual eating patterns?	yes	no
Explain:		
Does your child have unusual sleeping patterns?	yes	no
Explain:		

Family History

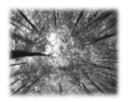
Current custody status:

Visitation arrangements:

What are your main approaches to discipline?

Which approaches to discipline have shown the most success?

Which family members, including extended family, suffer from any form of mental illness?



Smith & Associates Mental Health

Consent to Treat a Minor

Name of minor client:

Date of birth: _____

This is to certify that you give permission Smith & Associates Mental Health for the treatment of your child,

______. This treatment may include individual or group psychotherapy, counseling, and testing. This treatment may also include referrals to other appropriate State, County or other professional agencies.

One of my stipulations in treating your child is that you as a parent/guardian also be involved in the therapeutic process. By signing this consent form, you are also agreeing to attend occasional sessions at which I request your presence.

In addition, you as a parent/guardian agree to the following stipulations:

- Although your child is a minor, he/she has the right to confidentiality. This confidentiality is crucial for a child to feel safe and secure in the counseling environment and a necessary ingredient for treatment success. You agree to honor this right to confidentiality. Children age 14 and older have the right to full client privilege. Parents of children younger than 14 have the right to information regarding the minor's treatment so long as it is in the best interest of the child.
- In cases of divorce or parental conflict, you agree to not request that I participate in any court proceedings, to include but not limited to, testifying, providing records, or writing letters of summary or recommendation.

**I have a legal right to \Box sole / \Box shared medical decision making regarding the following children:

I understand that I may revoke this authorization by submitting my request in writing to Smith & Associates Mental Health

Name	Signature	Date
Name	Signature	Date

In cases of joint custody or shared allocation of parental responsibility for medical decisions, a copy of the divorce decree and custody order along with signatures indicating consent from **both parents are required in order to treat a minor, except in emergencies.