INTAKE FORM
ADOLESCENT or CHILD

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy. Please print out this form and bring it to your first session or allow yourself thirty minutes prior to your appointment to complete the form in the office.

Child's Name: _____ Age:_____ DOB: _____
Sibling: _____ Age:_____ In home? Y or N
Sibling: _____ Age:_____ In home? Y or N
Sibling: _____ Age:_____ In home? Y or N
Sibling: _____ Age:_____ In home? Y or N
Sibling: _____ Age:_____ In home? Y or N

Name of client's legal guardian(s): _____
DOB of legal guardian: _____/_____/_____
Child's/Guardian's primary address:

_____
(House number & Street) (Apt./Unit #)

_____
(City) (State) (Zip)

May we send mail to this address? □ Yes □ No

Home Phone: ( ) _____ May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) _____ May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No

*Please be aware that email might not be confidential.

Emergency contact (Not the primary guardian):

Name: _____ Relation: _____

Phone Number: (_____) _____

If different from primary legal guardian, please complete 1, 2, & 3 below:

1. Parent's Name: _____ DOB: _____
Address:_____
_____
Phone: H (____)_____ W (____)_____ C (____)_____
OK to contact? Yes _____ No_____

2. Parent's Name: _____ DOB: _____
Address:_____
_____
Phone: H (____)_____ W (____)_____ C (____)_____
OK to contact? Yes _____ No_____

3. Step-Parent's Name: _____ DOB: _____
Address:_____
_____
Phone: H (____)_____ W (____)_____ C (____)_____
OK to contact? Yes _____ No_____

****

Presenting Concerns:
Please describe the main concern(s) that brought you here today:
_____
_____
_____
_____
_____

1. Current Symptoms: (check any that apply)

	Aggression		Fatigue/low energy		Panic attacks
	Alcohol/Drug use		Fire-setting		Parent-Child conflict
	Anger		Grief/Loss		Peer-conflicts
	Anorexic/Bulimic behavior		Guilt/Shame		Phobias
	Anxiety/Stress		Hyperactivity		Self-Harm
	Appetite changes		Impulsive behaviors		Sexual behavior
	Concentration problems		Insomnia		Sleep problems

	Delusions/Hallucinations		Mood swings		Social isolation
	Depression		Obsession/Compulsion		Suicidal thoughts
	_____		_____		Weight changes

Please elaborate on any of the above: _____
_____
_____
_____
_____
_____

2. How do the symptoms affect the following areas of daily functioning?
Daily tasks _____
Family interaction _____
Recreational/Leisure activities _____
Relationships _____
Physical health _____
Self-esteem _____
School _____

Child and Family History

1. In the past 6 months to year, have there been changes in
Family structure (divorce, death, new baby, etc) _____
Living environment (new home, recent move) _____
School environment _____

2. Over the child's lifetime, has there been a history of
Abuse/Neglect _____
Out-of-home placement _____
Hospitalization _____

3. In the family, is there a history of
Abuse/Neglect _____
Substance use/abuse _____
Addictions _____
Suicide (or attempts) _____
Psychological conditions _____
Hereditary medical conditions _____

4. Who lives in the child's primary home _____
_____

5. Who has custody of the child? (Explain if needed) _____
_____

6. Are there other supportive adults in the child's life? (grandparents, aunt/uncle, coach) _____
_____

7. Is the child involved in extracurricular sports, clubs, or activities? _____
_____

8. Is the child currently taking medications? _____
_____

Developmental symptoms/concerns::
Over the child's lifetime, has s/he experienced the following:

Condition	Age	Condition	Age
Delayed speech		Learning delays	
Delayed walking		Fine motor problems	
Difficulty attaching		Gross Motor Problems	
Coordination problems		Over/under-weight	
Encopresis (defecation)		Separation anxiety	
Enuresis (wetting)		Stuttering	
Feeding problems		Other:	

Please elaborate on any of the above: _____
_____
_____
_____

Please share any other important information: _____
_____
_____
_____
_____