Valerie Hyatt-Martin, LCSW
Licensed Clinical Social Worker

INTAKE FORM - CHILD / ADOLESCENT

Family and important relationship information:

Parent(s):_____

Address: _____

Please list individuals who live in the home (Children, siblings, parents, friends, relatives)

_____

Current grade level_____

School _____

Performance in school_____

Birth Process: _____

Weight at birth _____

Difficulties as a newborn, toddler_____

_____

Preschool difficulties_____

_____

Developmental milestone concerns or difficulties:

_____

Present Situation: Please circle any of the following problems that pertain to client.

Anxiety	Nervousness	Agitation		
Depression/Sad	Fears	Suicidal thoughts	Motivation	Shyness
Conflict with peers	Aggressiveness	Separation/Divorce	Family financial stress	
Sexual Abuse	Physical Abuse	Drug/Alcohol Use		
School bullying	Family relationships	Anger		
Self-control	Unhappiness	Attention/Focus	Tension/Stress	Fatigue
Sleep problems				
Self harm/cutting	Headaches	Urge to repeat actions		
Too much energy	Panic attacks	Mood swings		
Loneliness	Feeling inferior	Withdrawal		
Racing thoughts	Physical health	Tantrums		
Nightmares	Eating issues	Recent loss		
Multiple losses				

What issues would you like addressed in therapy?

_____

_____

Health Information:
Family Physician: _____
Date of last physical exam: _____
Child on any medications? Yes____ No_____
If yes, list the type of medication and reason for taking it.
_____ _____ _____
_____
_____ _____ _____
_____
Significant health problems: _____
Has child had any previous therapy/counseling? Yes___ No ___
If yes, please give Therapist/Doctor, Agency, and when
_____
_____
Psychiatric Hospitalization? Yes___ No___ If yes, when/where:
_____
Has child experienced physical, sexual or other traumatic/disturbing experiences in childhood? Yes___ No____
_____
___
Client's or Authorized Person's Signature
I give my permission for Valerie Hyatt Martin, LCSW to provide mental health services for my child/adolescent.

_____
Parent/Guardian signature Date