

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 _____

Health Information:

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 ___

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

Physical Abuse

Drug/Alcohol Use

School bullying

Family relationships

Anger.

Self-control

Unhappiness

Attention/Focus

Tension/Stress

Fatigue

Sleep problems

Self harm

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

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