

# Finding Freedom Now, LLC

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## CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia law.

### BACKGROUND INFORMATION

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Child lives with (check one):  Both biological parents  Mother  Father  Other

If parents are divorced, describe custody arrangements:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's Home Phone: \_\_\_\_\_

Child's Address/City/State/Zip: \_\_\_\_\_

Emergency Contact Person (other than parent): \_\_\_\_\_

Phone Number: \_\_\_\_\_

What is the best way to contact you for appointment reminders?

Home  Work  E-mail  Cell  Don't contact

May we leave a message?  Yes  No

### INFORMATION ABOUT CHILD'S MOTHER

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home: \_\_\_\_\_ Email: \_\_\_\_\_

Church: \_\_\_\_\_ Denomination: \_\_\_\_\_

Active:  Yes  No

Describe any physical problems you have that require medication or physical care: \_\_\_\_\_

\_\_\_\_\_

Are you currently receiving medical treatment?  Yes  No

Physician's Name: \_\_\_\_\_

Medication(s) currently using: \_\_\_\_\_

Previous Counseling/Therapy:  Yes  No If yes, when: \_\_\_\_\_

With whom and for how long: \_\_\_\_\_

## INFORMATION ABOUT CHILD'S FATHER

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home: \_\_\_\_\_ Email: \_\_\_\_\_

Church: \_\_\_\_\_ Denomination: \_\_\_\_\_

Active:  Yes  No

Describe any physical problems you have that require medication or physical care: \_\_\_\_\_

Are you currently receiving medical treatment?  Yes  No

Physician's Name: \_\_\_\_\_

Medication(s) currently using: \_\_\_\_\_

Previous Counseling/Therapy:  Yes  No If yes, when: \_\_\_\_\_

With whom and for how long: \_\_\_\_\_

## FAMILY MEMBERS

List all people now living in the household: (In addition to parents/guardians)

Name	Relationship to Child	Age	School Grade Completed	Occupation

DESCRIBE THE ISSUE the child is having. If possible, list questions for which answers are sought:

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### Problem Areas:

In the following list, please prioritize each item which identifies an area of concern to you by numbering them. For example, the number 1 would be placed by the item which concerns you the most today:

No.	List 1	No.	List 2
	Anger		Fearfulness
	Sexual Concerns		Use of Alcohol/Drugs
	Depression		Friendship Problems
	Thoughts of Suicide		Bullying
	Education		Self-Harm
	Trouble Making Decisions		Impulsive Behavior
	Family Problems		Trouble Concentrating
	Unhappy Most of the Time		Feelings of Worthlessness
	Anxiety		

**CHILD'S MEDICAL HISTORY:**

List child's sicknesses, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious.

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Have there been any previous psychological, psychiatric, neurological, or EEG evaluations?

\_\_\_\_ Yes    \_\_\_\_ No    If yes, please list names and dates of contact:

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Describe previous speech or hearing therapy, if any:

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What is the date of your child's last physical examination? \_\_\_\_\_

Physician's Name: \_\_\_\_\_

**ACADEMIC/SCHOOL INFORMATION:**

School Name: \_\_\_\_\_ Grade: \_\_\_\_\_

How does your child get along with peers and authorities at school?

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Describe difficulties in learning at school:

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Describe what your child likes to do for fun, special interests, hobbies, etc.

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Describe your child's religious background (denomination, church membership, attendance, spiritual training, bible reading, prayer, etc.)

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I learned about Finding Freedom Now from (Name, Address, Phone if known):

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May we send a thank you note to this person?    \_\_\_\_ Yes    \_\_\_\_ No

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date