Comprehensive Mental Health
13341 US 290 BLDG 1-103, Austin Texas 78737
contact@comp-mh.com

Child's Information

Full Legal Name: _____

Date of Birth: _____ Sex: _____ SSN: _____

Cell (if applicable): _____ circle if ok to: call text leave voicemail

Email (if applicable): _____

Preferred method of communication (circle one): phone email

Address: _____

Race & Ethnicity: _____

Gender Identity: _____ Sexual Orientation: _____

Parent's Information

Full Legal Name: _____

Date of Birth: _____ Sex: _____ SSN: _____

Cell: _____ circle if ok to: call text leave voicemail

Email: _____

Preferred method of communication (circle one): phone email

Address: _____

Race & Ethnicity: _____

Gender Identity: _____ Sexual Orientation: _____

Insurance Information

Insurance Company: _____

Insurance ID: _____ Group ID: _____

RX Preferred Pharmacy Name & Location: _____

1st Next of Kin/Emergency Contact Information

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Name: _____

Relation: _____ Phone Number: _____

2nd Next of Kin/Emergency Contact Information

Name: _____

Relation: _____ Phone Number: _____

Child Intake Questionnaire

Medical Information

Physician Name: _____

Physician's Address: _____

Physician's phone number: _____

Does your child have any current health condition? yes no

List any medications your child is currently taking, including the dosage, frequency, and any side effects experienced:

_____
_____
_____

Does your child currently have any diagnoses? yes no

Educational Information

Does your child attend school? yes no

Name of school: _____

Classroom Type: _____ Teacher/Grade: _____

Address: _____

Current/Previous Therapy Provider Information

Therapist Name: _____

Phone Number: _____

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Therapy Dates of Service: _____

Please state the reason(s) you previously brought your child to therapy and the progress made:

_____
_____
_____

Describe any current family dynamics or environmental concerns that may be contributing to your child's mental health:

_____
_____
_____

Child's Current Behaviors and Expected Outcomes

Please provide detail regarding the concerns of your child's development, if any.

_____
_____
_____

Please describe any problem behaviors or interfering behaviors of concern:

_____
_____
_____

Please state the expectations/goals that you have for your child in therapy:

_____
_____
_____

Please list any other information that may be helpful while assessing and/or conducting therapy with your child:

_____
_____
_____

Referred By: _____

YOUR THERAPIST'S NAME: _____

EMAIL: _____

PHONE NUMBER: _____