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Child Intake Form

Name _____
(first) (last) (middle initial)

Birth Date _____ /_____ /_____ Age _____ Gender ☐ male ☐ female

Parent/Legal Guardian _____ Occupation _____

Other Adult Involved _____ Occupation _____

If any, how many siblings (including age) in home or other family members _____

_____

Address: _____
(street and number)

_____
(city) (state) (zip)

Main Phone: ( ) May I call and leave a message? ☐Yes ☐ No

Other Phone: ( ) May I call and leave a message? ☐Yes ☐ No

E-mail: _____ May I e-mail you? ☐Yes ☐ No

Current School _____ Grade _____

Previous Schools _____

Are there any concerns about school related issues? If so, please explain _____

_____

_____

Briefly describe other non-academic concerns you have _____

_____

_____

What are your child's strengths? _____

_____

What are your child's interests? _____

_____

Please complete if your child has previously received mental health services (counselor, psychologist psychiatrist):

Provider's Name	Start Date/End Date	Focus of treatment

General Health and Mental Health Information

Name of Personal Physician/Clinic: _____

Physician Phone Number: _____

Please list both current and previous prescription medications starting with active prescriptions:

Name of Medication	Dosage	Start Date	Comments

1. How would you rate your child's overall health?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

Please list any specific health problems you are having: _____

_____

2. How would you rate your child's current sleep habits?

☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good

3. Is your child engaging in physical activity?

☐No

☐Yes _____ days per week. Type of exercise _____

4. Please list any difficulties with eating patterns or appetite: _____

_____

5. Is your child currently experiencing intense anxiety, panic attacks or phobias?

☐No

☐Yes, this began _____

_____

6. Is your child currently experiencing overwhelming grief, sadness or depression?

☐No

☐Yes, this began _____

_____

7. What stressful events or life changes has your child or family experienced lately? _____

_____

_____

_____

Current Symptoms

Please check any of the following that pertain to your child

☐Anxiety	☐Elevated Mood	☐Mania	☐Poor Impulse Control
☐Anger	☐Grief/Loss	☐Memory Issues	☐Poor Self-Esteem
☐Appetite Disturbance	☐Guilt	☐Obsessions	☐Purging
☐Binging	☐Hallucinations	☐Oppositional	☐Self-injury (cutting)
☐Compulsions	☐Hopelessness	☐Panic Attacks	☐Sleep Disturbance
☐Decreased Energy	☐Hyperactivity	☐Paranoia	☐Weight gain/loss
☐Depression	☐Irritable	☐Poor Concentration	☐Withdrawn

Other: _____

_____

Current Functioning

☐Noticeable decrease in productivity	☐Medication misuse or non-compliance
☐Fewer social contacts	☐Argumentative/Verbal Hostility
☐Decrease in self-care	☐Absent 2 days or more from school/work
☐Drop in grades (if applicable)	☐Medical LOA due to psychiatric problem
☐Suspension from work/school	☐Difficulty finding motivation

Family Mental Health History

In the section below please identify if there is a family history of any of the following. If yes, please list the family member's relationship to you (mother, father, uncle grandmother, etc).

	Please check	List of all Family Members Affected
Alcohol/Substance Abuse	☐Yes ☐ No	
Anxiety	☐Yes ☐ No	
Bipolar	☐Yes ☐ No	
Depression	☐Yes ☐ No	
Domestic Violence	☐Yes ☐ No	
Eating Disorder	☐Yes ☐ No	

Obsessive Compulsive Disorder	☐Yes ☐ No	
Schizophrenia	☐Yes ☐ No	
Suicide Attempts	☐Yes ☐ No	

How were you referred to me? _____

_____

Please note anything else you would like me to know _____

_____

Emergency Notification

Name _____
(First) (Last) (Middle Initial)

Address _____
(street number)

_____
(city) (state) (zip)

Phone ( ) Relationship _____

Client Signature

_____ _____
Client Signature (for those 13 years or older) Date

_____ _____
Parent/Guardian Signature (younger than 13) Date