I N T A K E F O R M
Child and Teen

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Please provide the following information and answer the questions below. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Child's Name:
_____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

_____
Address:
_____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: ( ) _____May we leave a message? □Yes □No

Cell/Other Phone: ( ) _____May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: _____ /_____ /_____ Age: _____

Gender: □ Male □ Female □ Transgender

How were you referred for services?
_____
_____

A. Type of services you are seeking: □ Individual □ Family □ Parent-Child

Please describe the main difficulty that has brought you to see me:

_____

_____

_____

_____

_____

_____

_____

_____

B. Are caregivers currently employed? □ No □ Yes

If yes, what is the current employment situation?

_____

C. Sibling(s): **(please note, if you are here for family or parent-child services please fill out the part of this form entitled, "For Families, Couples, and Parent-Child")**

Name Current Age School Grade Any Concerns?

_____

_____

_____

_____

D. Parent Relationship Status:

□ Never Married □ Domestic Partnership □ Married □ Separated

□ Divorced □ Widowed

E. Relationships in your family-of-origin: Please describe the following:

1. Your parents' relationship with each other:
   _____
   _____
   _____
   _____

2. Your relationship with each parent and with other adults in your family:
   _____
   _____
   _____
   _____

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties:
   _____
   _____
   _____

4. Your relationship with your brothers and/or sisters, in the past and present:
   _____
   _____
   _____

F. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner:

_____

G. Are you currently taking any prescription medication?

□ Yes

□ No

Please list:

_____
_____

H. Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates:

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

3. Do you have any concerns about the quality of your sleep? (If yes, please describe)_____

(a) How many hours per night do you sleep?

_____

4. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

5. Please list any difficulties you experience with your appetite or eating patterns.

_____

6. Are you currently experiencing overwhelming sadness, grief or depression?

□ No

□ Yes

If yes, for approximately how long? _____

7. Are you currently experiencing anxiety, panic attacks or have any phobias?

□ No

□ Yes

If yes, when did you begin experiencing this? _____

8. Are you currently experiencing any chronic pain?

□ No

□ Yes

If yes, please describe? _____

9. Do you drink alcohol more than once a week? □ No □ Yes

10. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly

□ Infrequently □ Never

11. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

ADDITIONAL INFORMATION:

1. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

2. What do you consider to be some of your strengths?

_____

_____

_____

_____

3. What do you consider to be some of your weakness?

_____

_____

_____

4. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, Please indicate the family member's relationship to you in the space provided (father, Grandmother, uncle, etc.).

Please list family member:

Alcohol/Substance Abuse yes/no

Anxiety yes/no

Depression yes/no

Domestic Violence yes/no

Eating Disorders yes/no

Obesity yes/no

Obsessive Compulsive Behavior yes/no

Schizophrenia yes/no

Suicide Attempts yes/no

Other notes about family history:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

For Families and Parent-Child Clients

Please answer the following additional questions:

a. How do you get along with your children?_____
_____
_____
_____
_____

b. Write 3 descriptors for your ***relationship*** with your child:

_____,_____,_____