Child Intake Information

Name of Child: _____

Date of Birth: _____ Age:_____ Gender:_____

Present School: _____ Grade: _____

Address: _____

City/State: _____ Zip Code: _____

Parent/Guardian Names: _____

Phone (H): _____ (C):_____

Email address: _____

Parent's Marital Status (circle one):Single Widowed Divorced Separated Married

People living in the household (list name, relation, age, occupation):

_____

_____

_____

_____

Parents' Employer: _____

Occupation: _____

Length of current employment: _____

List parent's highest degree completed in education: _____

Reason for referral or reason you are seeking treatment. Who referred you?

Recent significant events, changes or stressors in your life:

Previous therapy? When and did you find it helpful?

List any significant health problem, mental illness, or recent death of family members (including grandparents, siblings).

Pediatrician Name:

_____

Current Medication for Child:

_____

_____

Birth Information (include any problems during pregnancy/delivery, complications, and/or delay in developmental milestones)

_____

_____

_____

_____

List your concerns for your child and what you would like to see change.

_____

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