Child/Adolescent Client Intake Form

Date_____

Client Name_____
Last First MI

Age_____ DOB_____

Gender assigned at birth_____ Preferred Pronouns_____

Address_____
Street City ST Zip

County_____ Home Phone_____

Name of School_____ Grade_____

Name of Legal Guardian (s)_____

Child Resides with: Both Parents_____ Mother____ Father____ Other_____

Parent Name_____

Address_____
Street City ST Zip

Home Phone_____ Cell Phone_____

Education: Years_____ Highest Degree_____ Field_____

Occupation_____Employer_____

Work Phone_____ Msg OK_____

Parent Name_____

Address_____
Street City ST Zip

Home Phone_____ Cell Phone_____

Education: Years_____ Highest Degree_____ Field_____

Occupation_____Employer_____

Work Phone_____ Msg Ok_____

Parent's Marital Status (Include dates):

Married_____ Separated_____ Divorced_____
Widowed_____ Living Together_____ N/A _____

Is your child adopted? Yes_____ No_____

If yes, at what age and any pertinent information_____

_____

Sibling Information:

Names and ages of full siblings_____

_____

Names and ages of step/half siblings_____

_____

Names and relationship of others living with child_____

_____

Child's Physician_____Phone_____

Address_____

Major medical illnesses/conditions and dates:_____

_____

Current Medications:
Medication Dosage Prescribed by Reason

_____

_____

_____

Referred By: Name_____ Phone_____

Presenting problem/ Reason for seeking treatment now:_____

When was the problem first noticed? _____

Has your child had previous psychiatric care and/or counseling? Yes____ No____

If yes, please give:
Name of clinician (s) Reason Year/How long?

Has your child had Psychological or Educational Testing done? Yes_____ No_____

Psychological Testing done by_____ Date_____

Educational Testing done by_____ Date_____

Other_____ Date_____

Is there any other information that you think may help me in working with your child?