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Child Intake Form

| Child's Name | <u> </u> | Birth Date: | / | E Gender | r: |
|-------------------------------|--|-------------------|---------------------|---------------|----------|
| Referred by (| if any): | | | | |
| Name of pare | nt/guardian: | | | | |
| Name of pare | nt/guardian: | | | | |
| Client Addres | SS: | | | | |
| | Street and Number | | City | State | Zip Code |
| Phone #1 | □ Home □ Cell □ Work | Phone #2 | □ Home □ Cell | □ Work | |
| May we leave | a message? □ Yes □ No | May we leav | ve a message? □ Ye | es ¬ No | |
| inay we leave | a message. E res E no | indy we lea | ve a message. 🗆 T | | |
| *Please note: | though email is encrypted, there nication. Please see informed con | are risks with s | ending personal h | ealth informa | tion via |
| School: | | Grade: | | | |
| Any children Children and | ildren parents have together: from previous relationships? Par others living in household: | rent 1: Pa | | | |
| Relationship | to client | | - | | |
| Name: | | Age: | | | |
| Relationship | to client | | - | | |
| Name: | | Age: | | | |
| Relationship | to client | | - | | |
| Name: | | Age: | | | |
| Relationship | to client | | - | | |
| Name: | | Age: | | | |
| Relationship | to client | | - | | |
| Name: | | Age: | | | |
| Relationship Has your chil | to client d had any previous counseling? | Yes 🗆 No ' | With whom? | | |
| Has your chil | d ever been hospitalized for men | tal health issues | ? □ Yes □ No Wi | ith whom? | |

| Family History of Mental Illness? If yes, please describe: | |
|---|--|
| Family History of Substance Abuse? If yes, please describe: | |
| Medical History Child's Physician's Name: Medical Clinic Name: Fax: Current medications (to include vitamins) and dosage: | Phone: |
| Any allergies? If yes, please describe: Any difficulties with the pregnancy or birth? If yes, please describ | be: |
| Any alcohol/substance use (including nicotine) during pregnancy Any major accidents, illnesses, injuries: If yes, please describe: | y? If yes, please describe: |
| For divorced or separated parents, please describe the custody a | rrangement*: |
| *(Please bring a copy of your parenting plan if you have one) |) |
| O | od 🗆 Excellent Excellent Excellent |

| Mark the behaviors you notice about your child | Not True | Sometimes True | Very True | | | | |
|---|-----------------------|----------------|-----------|--|--|--|--|
| Sad or depressed | | | | | | | |
| doesn't get along with others | | | | | | | |
| lying or cheating | | | | | | | |
| disobedient at home | | | | | | | |
| disobedient at school | | | | | | | |
| nightmares | | | | | | | |
| inappropriate sexual behaviors | | | | | | | |
| anxiety or nerves | | | | | | | |
| talks about killing self | | | | | | | |
| talks about killing others | | | | | | | |
| gang-like behavior | | | | | | | |
| impulsive behavior | | | | | | | |
| sudden mood swings | | | | | | | |
| withdrawn from family/friends | | | | | | | |
| difficulty concentrating | | | | | | | |
| feels worthless or inferior | | | | | | | |
| can't sit still | | | | | | | |
| poor school work | | | | | | | |
| wets bed bathroom accidents in clothing | | | | | | | |
| temper tantrums | | | | | | | |
| runs away from home | | | | | | | |
| cutting/other self-harmful behavior | | | | | | | |
| physically attacks others | | | | | | | |
| sleep problems | | | | | | | |
| alcohol or drug problems | | | | | | | |
| skips or refuses school | | | | | | | |
| vandalism | | | | | | | |
| sexually active and/or risky sexual behavior | | | | | | | |
| other: | | | | | | | |
| Consent By signing below, I agree that I have the legal authority to make medical and legal decisions for this child. I agree to have this child participate in therapy with Megghan Thompson, LCPC, RPT-S. | | | | | | | |
| Signature of Parent/Guardian | | Date | _ | | | | |
| Printed Name of Parent/Guardian | Relationship to Child | | | | | | |
| Printed Name of Child | | | | | | | |