YOUR STORY COUNSELING

CHILD INTAKE FORM

(*Please print and complete all items on this form)

CLIENT INFORMATION

Name of person filling out this form:
_____

Child's Name: _____

Date of Birth:____/____/____

Address:
_____
City Zip Home
Phone: (____)_____ Work: (____)_____ Cell: (____)_____

Social Security Number: _____ Age: _____ Gender:

☐Male ☐Female

Race (optional): ☐ African American ☐Asian ☐☐Hispanic ☐ White ☐_____
(Specify)

Parents are currently: ☐Married ☐Separated ☐ Divorced ☐Remarried ☐_____
(Specify)

Child's legal guardian is:
_____

Mother's Name:
_____

Address:
_____
City Zip Home Phone:
_____ Work: _____ Cell: _____

Father's Name:
_____

Address: _____

Home Phone:_____ Work: _____ Cell: _____

Stepparent's Name(s):

_____

Address:

_____

City Zip

Home Phone: _____ Work: _____ Cell: _____

Please list the names and ages of any siblings including step and half siblings:

_____

_____

Name of current school attending, and grade level:

_____

CLIENT HISTORY

1. Has your child ever received counseling, psychological, alcohol or drug treatment before?

☐ Yes ☐ No If yes, please indicate:

From Whom? For what? When? With what results?

_____

_____

_____

2. Has your child ever been prescribed medications for psychiatric or emotional problems?

☐ Yes ☐ No If yes, please indicate:

From Whom? For what? Name of Medication(s) With what results?

_____

_____

_____

3. Please list any inpatient psychiatric hospitalization/s: (include dates of treatment)

_____

_____

_____ 4. Please list name of your child's primary care physician:

_____

_____

_____

Phone Number Address City Zip

May Therapeutic Partners, PLLC contact your primary care physician to coordinate your care? ☐ Yes ☐ No

5. Please list any current medical illnesses, or health-related concerns:

_____

_____

6. Please list any current medications: (include name of doctor prescribing medication and any over the counter medications or herbal remedies)

_____

_____

7. Please list any hospitalizations or surgeries: (include approximate dates)

_____

_____

8. Does your child have any current legal charges, court involvement or under court order to receive services? ☐ Yes ☐ No If yes, please explain:

_____

_____

9. Please list any family history of mental illness or chemical dependency:

_____

_____

_____

10. What are your goals for counseling?

_____

_____

SYMPTOMS LIST

PLEASE CHECK ALL THAT APPLY:

***Parents, if possible, please allow your child to complete this form. If your child is too young, complete symptom check list from your observations of your child.**

	Headaches		Memory problems		Depression
	Sleep problems		Heart palpitations		Feeling tense or nervous
	Academic concerns		Ideas of harming yourself		Drug use
	Worries about money		Feeling shy around others		Not confident
	Having a lack of friends		Stomach problems		Concerned about eating habits
	Feelings of panic, fear, phobias		Trouble concentrating		Alcohol use
	Feeling sad or depressed		Grief or loss		Nightmares

	Feeling restless		Feelings of hopelessness		Feelings of worthlessness
	Low self-esteem		Disturbing thoughts		Hallucinations
	Aggression		Mood swings		Recurring thoughts
	Chest pain		Suicidal thoughts		Trembling
	Sexual concerns		Sexual identity concerns		Anger
	Ideas of harming others		Memory problems		Chronic pain
	Blaming or criticizing self		Abusing others		Dizziness
	Feeling tired		Feeling a need to be on the go		Problems at home
	Anxiety		Antisocial or illegal behavior		Concerned about family members
	Irritability		Abused by others		Sick often
	Isolating self		Disorganized thoughts		Relationship problems
	Distractibility		Impulsive		Poor judgment

Please add any other information about your child that would be helpful for the counselor to know.

_____

_____

_____

_____

Signature of Parent or Guardian _____ Date _____

Signature of Parent or Guardian _____ Date _____

Signature of Parent or Guardian _____ Date _____

Signature of Parent or Guardian _____ Date _____

Signature of Parent or Guardian _____ Date _____

Signature of Minor Child _____ Date _____

Signature of Therapist _____ Date _____