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CHILD INFORMATION

Name of Child:_____ Date:_____

Primary Address:_____
Street City Zip Code

Birth Date:_____ School:_____

Grade:_____ Teacher:_____

Mother:_____ Occupation:_____

Address: _____

Home Phone #:_____ **E-Mail Address**:_____

Cell Phone #:_____ Work Phone # :_____

Father:_____ Occupation:_____

Address: _____

Home Phone #:_____ **E-Mail Address**: _____

Cell Phone #:_____ Work Phone #: _____

Child's Previous Therapy:_____
Therapist's Name Period of Time Therapy Issue

Physician:_____ Phone:_____

Please describe your child's living arrangements (with whom, time split, etc.) and list other children in the home(s): _____

_____ _____
Name Age Relationship Name Age Relationship

In case of emergency, please notify:_____

Relation: _____ Phone:_____

Who referred you to my practice?_____

It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person**. No other information will be disclosed.

Signature:_____ Date:_____

INTAKE INFORMATION

Why are you seeking therapy for your child at this time? _____

_____

_____

_____

Check any symptoms your child has exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Appetite/Weight Loss
___ Insomnia
___ Excessive Sleep
___ Giving Up Easily
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Difficulty with Authority Figures
___ Often in Trouble
___ Argumentative
___ Other (please describe): _____

___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Excessive Nightmares
___ Difficulty Sleeping in Own Bed
___ Very Active
___ Easily Distracted
___ Has Conflicts with Peers
___ Doesn't Follow Directions

List and describe any history of emotional disorder(s) in your child's biological family:

_____

_____

_____

List and describe any significant life events (e.g. divorce, death in family, etc.):

_____

_____

_____

_____

How does your child function at school (i.e. grades, with peers with teachers)?

_____

_____

_____

_____

List and describe your child's current or historical physical problems (e.g. weight gain, headaches, hypoglycemia, stomachaches, etc.):

_____

_____

_____

_____

List any medication(s) and dosage your child is currently prescribed: _____

_____

_____

_____

Prescribing Physician: _____ Phone: _____

What are your child's strengths and hobbies? _____

_____

_____

_____

List your three primary treatment goals:

1. _____
2. _____
3. _____

Signature:_____ Date:_____
