Child Intake Form

Date_________________

Child Name_______________________________Age:_____DOB:__________

Address:____

Sex:_______Gender:_____________________ Race:____________________

Phone Number:___________________Can Voicemail be left?________________

Legal Guardian name and number:_______________________________________

If in state custody, Caseworker name and number:___________________________

If child has a GAL, GAL name and number:_________________________________

Insurance Name and ID Number____

Medical Problems: ____

Medications: ____

Previous Hospitalizations: ____

How did you hear about us:____

History of Suicidal thoughts: ____

Current Suicidal thoughts: ____

Drug use: ____

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History of Head Injury(ies): ____

Did Client meet developmental milestones on time? _________________________

Doctor: ______________________________

Last appt: ____________________________________

Food or Drug Allergies: ____

Emergency Contact Name ____________________________

Relationship: __________________ Phone Number: __________________

Please list the names and ages of individuals living in the home:

____

____

____

Credit Card Information

Card number _______________________ Expiration Date: _______________

CVC: __________ Zip Code: _____________ House number: __________

________ Initial here indicating that you agree to pay your copay or full fee at the time of the session with the above card information. If you would like to use a different payment method you understand that you must inform counselor or office staff at the beginning of the session.

Check the following you/your child want to work on during treatment:

___Depression	___Anxiety	___Auditory Hallucinations
___Suicidal thoughts	___Panic Attacks	___Visual Hallucinations
___Homicidal thoughts	___Alcohol use	___Paranoia
___Aggression	___Drug Use	___Obsessive thoughts
___Eating Disorder	___Traumatic Event	___Compulsive Behavior
___Weight	___Anger outbursts	___Bullying
___Chronic Illness	___Running away	___ Drug use (others)
___Impulsive Behaviors	___Parenting	___Relationship Problems
___Abuse History	___Sex Problems	___Sexual Orientation
___Identity	___Spiritual	___Autism
___Legal Problems	___Fear/Phobia	___Social Skills
___Nightmares	___Sleep	___Appetite
___Head Injury	___Impulsive	___Self Harm
___Irritable	___Domestic Violence	___Harm to animals
___Property Destruction	___Hoarding	___Grief

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