Maggie Benedict-Montgomery, Ph.D.
Licensed Clinical Psychologist, PSY28824
Supporting Children, Adolescents & Families

Intake Form: Child & Family Therapy

Parent's Name:

Birth Date:

Address:

Cell Phone: Home Phone:

- ❏ Ok to leave message on cell phone?
- ❏ Ok to text for scheduling?
- ❏ Ok to leave message on home phone?

Email Address:

- ❏ Ok to email for scheduling?

Parent's Name:

Birth Date:

Address:

Cell Phone: Home Phone:

- ❏ Ok to leave voicemail on cell phone?
- ❏ Ok to text for scheduling?
- ❏ Ok to leave message on home phone?

Email Address:

- ❏ Ok to email for scheduling?

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Parent(s) are currently

- ❏ Married
- ❏ Separated
- ❏ Divorced
- ❏ Other (describe):

If separated/divorced, is there a court ordered custody plan?

- ❏ Joint legal custody
- ❏ Sole legal custody

Held by:

Please describe physical custody/visitation arrangement:

Child's Name:

Birth Date:

School and Grade:

Important people in child's life (e.g. siblings, grandparents, cousins, mentors, coaches):

Name	Age	Relationship to child	Lives w/child?

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Pediatrician & Phone Number:

Medications:

Allergies:

History of medical issues or conditions? (ie broken bones, asthma)

In the first two years of life, did your child experience:

__Separation from primary caretaker

__Out of home care

__Disruption in bonding

__Depression of primary caretaker

__Abuse

__Neglect

__Chronic pain

__Chronic Illness

__Parental Stress

If yes, please specify:

Was your child adopted by either parent?

___Yes ___No

If so, when did you/they became child's caregiver?

Reached developmental milestones: __On time, __Early, __Late, __Unknown

Has your child ever been diagnosed learning or developmental disability?

- ❏ Yes

- ❑ No
- ❑ I'm not sure

Please specify diagnosis:

Date Diagnosed

By whom?

Has your child ever been diagnosed with a mental health condition?

- ❑ Yes
- ❑ No
- ❑ I'm not sure

Please specify diagnosis:

Date Diagnosed

By whom?

Has your child ever experienced abuse (verbal, physical, emotional, sexual)?

- ❑ Yes
- ❑ No
- ❑ Suspected

Please specify:

Have you or your family had prior mental health treatment?

- ❑ Yes
- ❑ No
- ❑ Unknown

Clinician Name and Type of treatment:

Dates of treatment:

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Clinician Name and Type of treatment:

Dates of treatment:

Description of current concerns:

How long has the problem been occurring?

What are your hopes for therapy?

What would the best possible outcome of therapy be?

What are your child's three greatest strengths?

1)

2)

3)

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What are your child's three greatest challenges?

1)

2)

3)

What are five adjectives that describe:

Primary Caregiver:

Co-parent:

Child:

Your family:

Caretakers' Relationship:

Who else will be involved in therapy?

Name	Relationship to child

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Emergency Contact:

In case of emergency, contact:

Name *Relationship to child*

Address *Phone Number*

Form Completed by:

Name *Date*

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