

**Intake Form: Child & Family Therapy**

Parent's Name:

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Birth Date:

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Address:

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Cell Phone:

Home Phone:

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

Email Address:

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- Ok to email for scheduling?

Parent's Name:

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Birth Date:

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Address:

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Cell Phone:

Home Phone:

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

Email Address:

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- Ok to email for scheduling?



Parent(s) are currently

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

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

- Joint legal custody
- Sole legal custody

Held by:

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Please describe physical custody/visitation arrangement:

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Child's Name:

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Birth Date:

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School and Grade:

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

<u>Name</u>	<u>Age</u>	<u>Relationship to child</u>	<u>Lives w/child?</u>
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Pediatrician & Phone Number:

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Medications:

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Allergies:

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

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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:

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Was your child adopted by either parent?

Yes  No

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

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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:

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Date Diagnosed

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By whom?

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

- Yes
- No
- I'm not sure

Please specify diagnosis:

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Date Diagnosed

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By whom?

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

- Yes
- No
- Suspected

Please specify:

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Have you or your family had prior mental health treatment?

- Yes
- No
- Unknown

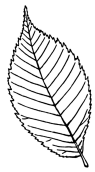
Clinician Name and Type of treatment:

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Dates of treatment:

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Clinician Name and Type of treatment:

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Dates of treatment:

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Description of current concerns:

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How long has the problem been occurring?

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What are your hopes for therapy?

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What would the best possible outcome of therapy be?

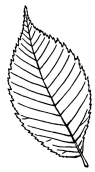
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What are your child's three greatest strengths?

- 1)
- 2)
- 3)



What are your child's three greatest challenges?

- 1)
- 2)
- 3)

What are five adjectives that describe:

Primary Caregiver:

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Co-parent:

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Child:

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Your family:

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Caretakers' Relationship:

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Who else will be involved in therapy?

Name

Relationship to child

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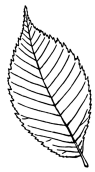
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**Emergency Contact:**

In case of emergency, contact:

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*Name*

*Relationship to child*

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*Address*

*Phone Number*

Form Completed by:

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*Name*

*Date*