# Child Intake Form

Child Intake Questionnaire

If child is too young to complete, parent please fill in the information below. Please note: information provided on this form is protected as confidential information.

Personal Information:

Date: _____

Name of Child:_____

Parent/Legal Guardian: _____

Address:

_____

_____

Home Phone___ ___ _____ May we leave a message? □ Yes □ No
Cell/Work/Other Phone: _____ May we leave a message? □ Yes □ No
Email: _____ May we leave a message? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Child's DOB: _____ Age: _____ Gender: _____
Referred By (if any):

_____

History Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? □ No □ Yes, previous therapist/practitioner:

_____

Are they currently taking any prescription medication? □ Yes □ No If yes, please list:

_____

_____

Have they ever been prescribed psychiatric medication? □ Yes □ No If yes, please list and provide dates:

_____

_____

General and Mental Health Information

How would you rate your child's current physical health?

(Please circle one) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems your child is currently experiencing:

_____

_____

How would you rate your child's current sleeping habits?

(Please circle one) Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems your child is currently experiencing:

_____

_____

Please list any difficulties your child experiences with his/her appetite or eating problems:

_____

_____

Is your child currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, for approximately for how long? _____

_____

Are they currently experiencing anxiety, panics attacks or have any phobias? □ No □ Yes

If yes, when did they begin experiencing this?

_____

_____

Have there been any significant life changes or stressful events for your child recently?

_____

_____

_____

Family Mental Health History

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child in the space provided (e.g. father, grandmother, uncle, etc.)

Please Circle and List Family Member

Alcohol/Substance Abuse yes / no _____

Anxiety yes / no _____

Depression yes / no _____

Domestic Violence yes / no _____

Eating Disorders yes / no _____

Obesity yes / no _____

Obsessive Compulsive Behavior yes / no _____

Schizophrenia yes / no _____

Suicide Attempts yes / no _____ ____

What do you consider to be some of your child's strengths?

_____
_____
_____
_____

What do you consider to be some of your child's weaknesses?

_____
_____
_____
_____
_____

What would you hope your child to accomplish out of their time in therapy? Answer only, if appt is for therapy. Disregard if appt is for an evaluation.

_____
_____
_____