Intake Form for Child/Adolescent Psychotherapy

Child's name: _____ DOB/Age: _____ /_____

Child primarily lives with: ___ Both parents ___ Mother ___ Father ___ Other _____

Mother's name: _____ DOB: _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Custody: _____

Please list others living in mother's home, ages, and relationship to child:

_____

_____

Father's name: _____ DOB: _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Custody: _____

Please list others living in father's home, ages, and relationship to child:

_____

_____

Step-parent's/Guardian's information: (If applicable) _____

Address: _____

Phone: (C) _____ (H) _____

Employer: _____

Who has legal guardianship of your child? _____

Please describe custody and the child's current living arrangements: _____

Is there any legal involvement with your child? Yes _____ No _____ If so, please describe: _____

_____

Please bring copies of any court orders that impact your child.
Who are your child's significant others living with your child? Please list their names, ages, relationships, grades, and jobs if applicable:

1. _____
2. _____
3. _____
4. _____

Who are your child's significant others *not* living with your child? Please list their names, ages, relationships, grades, and jobs if applicable:

1. _____
2. _____
3. _____
4. _____

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Child's name: _____ DOB/Age: _____ /_____

School attending and grade level (if applicable): _____

Child's job and employer (if applicable): _____

Work phone: _____ Work days and hours: _____

How were you referred: _____

Reason(s) for seeking therapy: _____

What goals do you have for therapy? _____

Have you sought mental health treatment before for your child? ___ Yes ___ No

If so, when and with whom? _____

_____

Current medical doctor/Family physician: _____

Phone number: _____

Current medications (type and dosage): _____

_____

Has there been any history or suspicion of physical, sexual, or emotional abuse? (If so please explain)

_____

_____

_____

Have there been any suicide attempts? (If so, explain) _____

_____

In case of emergency, please notify:

Name: _____ Phone: _____ Relationship: _____

Insurance (The following questions are about the policy holder.)

Policyholder's name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____

Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Insurance company: 1. (*Medical*) _____

2. (*Mental health*): _____

Authorization #: _____ Number of sessions authorized: _____ Co-pay: _____

Employer: _____

Job title: _____

If you are a dependent, what is your relationship to the policyholder: _____

By completing this form, my signature indicates that the information provided is truthful and accurate.

Form completed by: _____ Date: _____

Signature: _____