

CHILD CLIENT INTAKE FORM

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Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Date of first appointment:_____

GENERAL INFORMATION:

Last Name:_____First Name:_____Middle:_____

Birth Date:_____Age:_____Gender: ☐ Male ☐ Female

Address: _____

(Street and Number)

(City, State, & Zip)

Home Phone:_____May I leave a message? ☐Yes ☐ No

Cell Phone:_____May I leave a message? ☐Yes ☐ No

Email:_____May I email you? ☐Yes* ☐ No

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

Emergency Contact:_____Telephone:_____

Relationship to You:_____

Referred by:

☐Medical Provider:_____

☐Insurance Provider:_____

☐My Website

☐Psychology Today:_____

☐Friend/Family:_____

☐Other:_____

Referred By:_____

May I thank the person? ☐ Yes ☐ No If yes, please give the contact information:_____

Have you previously received any type of mental health services?

☐ Yes

☐ No

If yes, which of the following:

☐ Psychotherapy

☐ Medication

☐ Outpatient Hospitalizations

☐ Inpatient Hospitalizations

If yes, please provide:

Name of provider or facility: _____

Location: _____

Dates of treatment: _____

Reason for treatment: _____

Briefly, what brings you in today?

When did your issue first start? Within the last:

☐ 30 days

☐ 6-12 months

☐ 2 years

☐ During adolescence

☐ During childhood

What areas of your life have been affected because of this issue?

Are you currently experiencing overwhelming sadness, grief, or depression?

☐ Yes

☐ No

If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or any phobias?

☐ Yes

☐ No

If yes, what exactly are you experiencing and when did you begin experiencing this?

Please describe any major losses or traumas you have experienced.

Physical Health

Please list any medications, herbs, or supplements you take. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

Medication/Supplement	Dosage	Condition	Date Began/Stopped
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Prescribing provider and contact information:

Name: _____

Specialty: _____

Facility: _____

Phone, email, or fax: _____

How would you rate your current physical health?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

Please list any health problems you are currently experiencing:

How would you rate your current sleeping habits?

- ☐ Poor
- ☐ Unsatisfactory
- ☐ Satisfactory
- ☐ Good
- ☐ Very Good

If you are having problems, in which phase of sleep are you experiencing issues?

- ☐ Falling asleep
- ☐ Staying asleep
- ☐ Awakening early
- ☐ Sleep apnea

Please list any other specific sleep problems you are currently experiencing:

What do you do for fun?

What are the things you are good at?