Child / Adolescent Intake Form

Client information

Child's Full Legal Name: _____

Preferred Name / Nickname: _____

Date of Birth: _____

Age: _____

Gender Identity (optional): _____

Pronouns (optional): _____

Home Address: _____

Parent / Legal Guardian Information

Primary Guardian Name: _____

Relationship to Child:_____

Phone Number:_____

Email Address: _____

Yes / No

Do both parents/legal guardians have legal custody?

Please explain custody or guardianship arrangements:
_____

Emergency Contact (if different from guardian)

Emergency Contact Name: _____

Relationship: _____

Phone Number: _____

Insurance Information

Insurance Provider: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Member ID #: _____

School & Academic Information

School Name: _____

Current Grade: _____

Yes / No

Does your child have an IEP or 504 Plan?

If yes, please describe supports or accommodations:

_____

Academic Concerns:

- ☐ Attention / focus
- ☐ Behavior in class
- ☐ Learning difficulties
- ☐ Attendance issues
- ☐ Social difficulties

☐ None at this time

Reason for Seeking Services

Please describe what concerns led you to seek counseling for your child/adolescent at this time:

_____
_____
_____
_____

Goals for Counseling

What changes or improvements would you like to see as a result of counseling?

_____
_____
_____

Medical & Mental Health History

Pediatrician / Primary Care Provider: _____

Phone number: _____

Current medications (include dosage)

_____
_____

Yes / No

Has your child received counseling or mental health treatment before?

If yes, please describe previous services and outcomes:

_____

_____

Yes / No

Any significant medical conditions or developmental concerns?

If yes, please explain:

_____

Trauma & Life Experiences (Answer only what you feel comfortable sharing)

- ☐ Family conflict or separation
- ☐ Emotional abuse
- ☐ Physical abuse
- ☐ Sexual abuse or inappropriate sexual contact
- ☐ Domestic violence exposure
- ☐ Bullying (in-person or online)
- ☐ Loss or grief
- ☐ Foster care or adoption-related experiences
- ☐ Medical trauma
- ☐ Other:

  _____
- ☐ Prefer not to disclose

Would you like trauma-informed care to be part of treatment? _____

Safety & Suicide Risk Screening

- ☐ My child has talked about wanting to die
- ☐ My child has expressed thoughts of self-harm

- ☐ My child has engaged in self-harm behaviors
- ☐ My child has made a suicide attempt in the past
- ☐ None of the above

If any boxes were selected above, please provide details (optional):

_____

_____

Protective Factors:

- ☐ Supportive family
- ☐ Friends or peers
- ☐ Faith or spiritual beliefs
- ☐ Hobbies or interests
- ☐ Pets
- ☐ Other

Behavioral & Emotional Functioning

- ☐ Anxiety or excessive worry
- ☐ Sadness or depression
- ☐ Anger or emotional outbursts
- ☐ Defiance or oppositional behavior
- ☐ Difficulty with emotional regulation
- ☐ Sleep difficulties
- ☐ Social withdrawal
- ☐ Changes in appetite
- ☐ None of the above

If any, please provide detail such as time frame of issue(s), frequency, level of issue:

_____

_____

Strengths & Supports

What are your child's strengths, interests, or positive qualities?

_____

_____

Who are the important supportive people in your child's life?

_____

_____

Spiritual, Cultural, & Family Values (Optional)

Yes / No

Are cultural, spiritual, or family values important to consider in your child's counseling?

If yes, please share anything you would like your child's therapist to know:

_____

_____

_____

Consent & Acknowledgment

- ☐ I confirm that the information provided is accurate to the best of my knowledge and I consent to counseling services for my child.
- ☐ I understand that counseling is a collaborative process and that results cannot be guaranteed. I acknowledge that I have provided accurate information to the best of my ability.

Parent / Legal Guardian Signature:

_____

Date Signed: _____