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THERAPY INTAKE FORM (CHILD/ADOLESCENT)

Date of first appointment: _____

Please take your time providing the following information. The questions are designed to help me begin to understand your child, so that our time together can be as productive as possible. All information provided is confidential, unless you sign a release requesting otherwise.

Referred by:

_____ School: _____

_____ My website

_____ Psychology Today

_____ Medical Provider: _____

_____ Family/Friend: _____

_____ Other: _____

Name of Child: _____

Age: _____ Date of Birth: _____

Gender at Birth: _____

Identified Gender: _____

Preferred Name or Nickname: _____

Race: _____

Name of person completing this form: _____

Relationship to child: _____

Briefly explain the reason for seeking therapy for your child:

How long has this problem been causing your child distress?

Is your child adopted?

_____ Yes

_____ No

If yes, at what age was your child adopted? _____

Domestic or international adoption? _____

Parent #1 Name: _____ Age: _____

_____ Living with child

_____ Not living with child

Occupation: _____

Place of employment: _____

Parent #2 Name: _____ Age: _____

_____ Living with child

_____ Not living with child

Occupation: _____

Place of employment: _____

Marital status of parents: _____

Please list the names, ages, relationships, and other relevant information regarding family members living inside or outside the home. Also, please include all members currently residing in the child's household who may not be directly related.

Name	Gender	Age	Relationship to child	Living with child?

Other helpful information about family members or family relationships?

Any recent losses experienced? Explain.

Does your child have any physical health or medical issues?

_____ Yes

_____ No

If yes, please explain:

Has your child been in psychotherapy before?

_____ Yes

_____ No

If yes, name of former therapist: _____

Length of treatment: _____

Reason for treatment: _____

Is your child currently being seen by a psychiatrist or medication prescriber?

_____ Yes

_____ No

If yes, name of prescriber: _____

Length of treatment: _____

Reason for treatment: _____

Has your child ever received a mental health diagnosis?

_____ Yes

_____ No

If yes, what diagnosis was your child given? _____

When? _____

By whom? _____

Has your child been hospitalized for mental health or drug/alcohol concerns in the past?

_____ Yes

_____ No

If yes, please list reason for treatment: _____

Location of treatment: _____

Date of treatment: _____

Length of treatment: _____

Please identify any members of your family with a history of mental health concerns AND their diagnoses:

Has your child ever been abused or assaulted?

_____ Yes

_____ No

If yes, please explain:

Has your child ever been a victim of bullying?

_____ Yes

_____ No

If yes, please explain:

Do you worry about your child's safety?

_____ Yes

_____ No

If yes, please explain:

Has your child ever been known to bully other children?

_____ Yes

_____ No

If yes, please explain:

What strengths does your child/family have?

What challenges does your child/family have?

What/who does your child count on for support?

What else would you like for me to be aware of?