

Intake Form: Child & Family Therapy

Parent's Name:		
Birth Date:	and the second 	· · · · · · · · · · · · · · · · · · ·
Address:		
City:	Zip Code:	
Cell Phone:		namen militar kan
Home Phone:	The second secon	
Email Address:	***************************************	
Parent's Name:		
Birth Date:		
Birth Date:	as above):	
City:	Zip Code:	
Cell Phone:		
Home Phone:		
E-mail Address:	ter internet and finance or constructive descriptions and an activities are an activities and activities are a	
Child's Name:		
Birth Date:		
School:		
Grade:		
Pediatrician:		
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Allergies:		
Child's Name:		
Birth Date:		
School:		
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Pediatrician:		
Medications:		
Allergies:		ann ann an t-aireann a dean an t-aireann ann an t-aireann an t-aireann an t-aireann an t-aireann an t-aireann a
Please check:		
Married SeparatedD	ivorced	Other (describe)

If separated or divorced:			
Is there a court ordered custody plan?			
If Yes:			
Joint legal custody or Sole legal custody held by: Please describe physical custody/visitation			
Prior mental health treatment:			
Type:;			
Clinician:Dates:			
Type:;			
Clinician:Dates:			
Reason for seeking counseling services:			
How long has the presenting concern been occurring			
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Your goals and desired outcomes for counseling:	χ ² .		
Your goals and desired outcomes for counseling.			
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In case of emergency, contact:			
Name			
Address			
Phone Number			
Relationship			
Who referred you/ how did you find me:			
Form Completed by:			
Date:			