Intake Form: Child & Family Therapy

Parent's Name:_____
Birth Date: _____
Address:_____
City: _____ Zip Code:_____
Cell Phone: _____
Home Phone: _____
Email Address:_____

Parent's Name:_____
Birth Date: _____
Address (or indicate if same as above):
_____
City: _____ Zip Code: _____
Cell Phone: _____
Home Phone: _____
E-mail Address:_____

Child's Name: _____
Birth Date: _____
School: _____
Grade:_____
Pediatrician:_____
Medications:_____
Allergies:_____

Child's Name: _____
Birth Date: _____
School: _____
Grade:_____
Pediatrician:_____
Medications:_____
Allergies:_____

Please check:
Married_____ Separated_____Divorced_____ 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
arrangement_____
_____
_____
Prior mental health treatment:
Type:_____;
Clinician:_____Dates:_____
Type:_____;
Clinician:_____Dates:_____

Reason for seeking counseling services:

_____

_____

How long has the presenting concern been occurring?

_____

_____

Your goals and desired outcomes for counseling:

_____

_____

In case of emergency, contact:
Name_____
Address_____
Phone Number_____
Relationship_____
Who referred you/ how did you find me:
_____
Form Completed by: _____
Date:_____