**Child/Teen Intake Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for seeking therapy?

Physician’s name and phone number:

Who does the child live with? (Inc. names and ages of any siblings)

Parent/Guardian 2 (name and relationship):

Nickname/alias/AKA:

Name:

E-mail address:

Parent/Guardian 1 (name and relationship):

Contact phone:

Address:

Date of birth:

School/grade:

Has the child/teen been in therapy before? Yes No

Any current medications? Yes No (If yes, please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current or past medical conditions? Yes No (If yes, please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religious/Spiritual Orientation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s interests/hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if there is any family history of the following:

Illegal drug use? Yes No I’m not sure

Alcohol abuse? Yes No I’m not sure

Prescription drug abuse? Yes No I’m not sure

Mental illness/psychiatric hospitalization? Yes No I’m not sure

Abuse or neglect? Yes No I’m not sure

Domestic violence? Yes No I’m not sure

Is there anything else that you think I should know?