CHILD/ADOLESCENT INTAKE

Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Social Security Number: _____

Legal Guardian(s): _____

Mother Father Stepmother Stepfather Adoptive or Foster Parent(s)

Primary Address: _____

Phone: _____ E-Mail: _____

Work Phone: _____ Mobile Phone: _____

Siblings Names and Ages: _____

School: _____ Grade: _____

Primary Teacher / Counselor: _____

Special Programs? No Yes (Specify) _____

Has your child ever been retained? No Yes What grade(s)? _____

School Address: _____

School Phone: _____ Fax: _____

Primary Care Physician / Group: _____

Address: _____

Phone: _____ Fax: _____

List current medications and dosages: _____

Serious medical conditions? No Yes (Specify) _____

Has your child / adolescent received any previous psychological and/or psychiatric evaluations or treatment? No Yes (Specify)

_____

_____

Previous Diagnoses: _____

Does your child / adolescent use illicit drugs or drink alcohol? No Yes

Is your child sexually active? No Yes

Has your child ever attempted or talked about suicide? No Yes)

Is your child / adolescent physically aggressive or violent? No Yes

Has your child / adolescent ever been charged with and/or convicted of a crime? No Yes

Has your child / adolescent ever been sexually, physically or emotionally victimized or neglected? No Yes

Briefly explain why you have brought your child / adolescent:

_____

_____

How or by whom were you referred? (Explain)

_____