Child's Intake Form

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy.

Child's Name:

_____

(Last) (First) (Nickname)

Parent/Guardian Name

_____

(Last) (First)

Child's Birth Date: _____/_____/_____ Age _____

Other Children:_____.Ages_____

Parent's Local Address:
Street and Number_____
City _____State_____Zip _____

Parent's Home Phone _____May I leave a msg? yes ___no_____
Cell Phone _____ May I leave a msg? yes ___no____
_____ May I leave a msg? yes___no___

Child's cell phone_____ Child's email_____

Referred by:_____
May I thank the person who referred you? yes_____no_____

In case of Emergency:
Name _____Phone ( )_____

Has your child had previous psychotherapy yes_____no_____

Is your child currently taking prescribed psychiatric medication (antidepressants or others)? yes_____no_____Please list:_____-

Has your child been previously prescribed psychiatric medication?

yes_____no_____please list_____

Your Child's School_____ Grade_____

In the last year, has your child experienced any significant life changes or stressors yes_____please explain:_____
no_____

What do you consider your chid's strengths?_____
_____
_____

What do you consider your child's effective coping strategies?_____
_____
_____