## CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia law.

BACKGROUND INFORMATION								
Child's Name		Date	e of Birth	/	/	Age		
Child lives with (check one): both biological parents		mother fa			er	other		
If parents are divorced, describe custody arrangeme	nts:				ar or a second s			
Child's Address								
Emergency Contact Person (other than parent)		Phone Number						
Custodial parent's contact information: Phone								
Phone					(Work,	)		
Email								
Circle the best way to contact you for appointment	reminders: 1	Home	Work	E-mail	Cell	Don't contact		
May we leave a message? Yes No								
INFORMATION ABOUT CHILD'S MOTHER								
Mother's Name			Age	Race	e			
Employer								
Hrs/wk Can you be contacted at work by			No					
Circle the best way to contact you:								
Phone								
(Home)	(Cell)				(Work	)		
Email								
Denomination Ch	urch				A	ctive? Yes No		
Describe any physical problems you have that requ	ire medicatio	on or pl	nysical ca	re				
Are you currently receiving medical treatment? Y	es No P	hysicia	ın					
Medication(s) currently using								
Previous Counseling/Therapy? Yes No If								
With whom and for how long?								

## CHILD AND ADOLESCENT INTAKE FORM (CONT.)

INFORMATION ABOUT CHILD'S F Father's Name	ATHER			_ Age	Race	
Employer						
Hrs/wk Can you be contacted at work by phone? Yes			Yes	No		
Circle the best way to contact you:						
Phone						
(Home)	(0	(Cell) (Work)				
Email					A 0	
Denomination Church					Active?	Yes No
Describe any physical problems you hav	e that require r	nedicati	on or	physical care		
Are you currently receiving medical trea	tment? Yes	No I	Physic	cian		
Medication(s) currently using						
Previous Counseling/Therapy? Yes	No If yes,	when				
With whom and for how long?						
DESCRIBE THE ISSUE the child is h				Completed ons for which		
Problem Areas: In the following list, ple numbering them. For example, the num	ease prioritize of ber 1 would be	placed	by the	e item which c	oncerns you the mos	you by st today.
Anger				eligious/Spirit		
Depression			Sexual concerns			
Education		-	Thoughts of suicide			
Family problems			Trouble making decisions			
Fearfulness		-		nhappy most	of the time	
Marital problems				se of alcohol		
Physical problems				lse of drugs		
Problems with social relationsh	iips			Vork		
Problems with children			V	Vorry		
Othor						

## **CHILD'S MEDICAL HISTORY**

List child's sicknesses, operations, and injuries. Indicate age when occurred and describe how severe. Please pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious, difficult pregnancy or delivery:
Have there been any previous psychological, psychiatric, neurological, or EEG evaluations? Yes No
If so, please list names and dates of contact.
Describe previous speech or hearing therapy, if any
What is the date of your child's last physical examination?/ Physician's Name
ACADEMIC/SCHOOL INFORMATION
School Name         Grade         Teacher
How many previous schools attended, with dates:
Has child ever repeated a grade? Yes No If so, when?
How does your child get along with peers and authorities at school?
Describe difficulties in learning at school:
I would like copies of all special testing (s)he has needed for educational or psychological purposes.
Have other family members had learning difficulties? Yes No What?
Describe what your child likes to do for fun, special interests, hobbies, etc
Describe your child's religious background (denomination, church membership, attendance, spiritual training,
bible reading, prayer, etc.)

Activities you enjoy with your family
Activities you enjoy with your friends
Do you have physical limitations that prevent exercise or physical activity? No Yes  If yes, please describe?
Do you exercise on a regular basis? No Yes  If yes, how many times per week? (Check one) 1-2 times 3-4 times 5+ times
Are you able to separate drug / alcohol use from your activities? No Yes Sometimes NA

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