

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 of Birth ____/____/____ Age _____

Child lives with (check one): both biological parents _____ mother _____ father _____ other _____

If parents are divorced, describe custody arrangements: _____

Child's Address _____

Emergency Contact Person (other than parent) _____ Phone Number ____ - ____ - ____

Custodial parent's contact information:

Phone _____
(Home) (Cell) (Work)

Email _____

Circle the best way to contact you for appointment reminders: 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 _____

Employer _____ Occupation _____

Hrs/wk _____ Can you be contacted at work by phone? Yes No

Circle the best way to contact you:

Phone _____
(Home) (Cell) (Work)

Email _____

Denomination _____ Church _____ Active? Yes No

Describe any physical problems you have that require medication or physical care _____

Are you currently receiving medical treatment? Yes No Physician _____

Medication(s) currently using _____

Previous Counseling/Therapy? Yes No If yes, when _____

With whom and for how long? _____

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