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Client Intake Form – Child/Adolescent

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

CLIENT INFORMATION

Name _____ Date of Birth _____

Age _____ Sex _____ Gender/Preferred Pronouns _____

Parent / Legal Guardian (If under 18) _____

Parent / Legal Guardian (If under 18) _____

Address _____

Contact Phone Number(s) Cell _____

Other _____

Contact E-Mail Address _____

School Name _____

Grade _____ ☐ 504 Plan? ☐ IEP? ☐ Other Special Services? _____

Extra Curricular Activities/Hobbies _____

Ethnicity _____ Religion _____

EMERGENCY CONTACT NAME _____
* Please note, as stated in the "Safety" section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

Are you currently working with a physician, psychiatrist, or other healthcare provider?
Name & Practice Name _____

Would you like me to coordinate with this provider? ☐ Yes ☐ No

Client Health History

History of Mental Health Services - list age(s) & provider:

History of Psychiatric medication ☐ Yes ☐ No

List:

Current Medications: _____

Previous Mental Health diagnosis: _____

Relevant Medical Diagnosis: _____

History of alcohol / drug use? ☐Yes ☐No Describe: _____

Has the client ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, when? _____

Has the client ever made a plan to commit suicide or attempted suicide?

☐ Yes ☐ No If yes, when? _____

Does the client currently have thoughts of ending their life? ☐ Yes ☐ No

Please list any serious allergies _____

Please list additional information you would like me to know:

Client Interest in Counseling Services

Please describe what brings you (or your child/teen) to counseling:

Please check following symptoms or issues that apply to the client:

☐ Anxiety	☐ Depression	☐ Behavior at home
☐ Stress	☐ Sexuality	☐ Behavior at school
☐ Drug/Alcohol Use	☐ Anger	☐ Worry/Fear
☐ Self-esteem	☐ Abuse	☐ Strained relationship(s)
☐ Sleep Changes	☐ Cutting/Self-Harm	☐ Suicidal Thoughts
☐ Health Concern	☐ Life Change	☐ Grief and Loss
☐ Disordered Eating	☐ Trauma	☐ Decision Making/self control
☐ Focus/Attention	☐ Lack of motivation	☐ Divorce/Separation

Please describe client's thoughts about seeing a therapist: