



In case of emergency, please notify: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to my practice? \_\_\_\_\_

It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person.** No other information will be disclosed.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## INTAKE INFORMATION

Why are you seeking therapy for your child at this time? \_\_\_\_\_

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Check any symptoms your child has exhibited in the past six months:

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|--|---|
| <input type="checkbox"/> Sadness/Crying Spells             | <input type="checkbox"/> Nervousness/Jittery            |
| <input type="checkbox"/> Socially Isolated                 | <input type="checkbox"/> Irritable/Temper Outbursts     |
| <input type="checkbox"/> Appetite/Weight Loss              | <input type="checkbox"/> Persistent Thoughts            |
| <input type="checkbox"/> Insomnia                          | <input type="checkbox"/> Mood Swings                    |
| <input type="checkbox"/> Excessive Sleep                   | <input type="checkbox"/> Excessive Worrying             |
| <input type="checkbox"/> Giving Up Easily                  | <input type="checkbox"/> Fidgety                        |
| <input type="checkbox"/> Difficulty Having Fun             | <input type="checkbox"/> Excessive Nightmares           |
| <input type="checkbox"/> Excessive Anger/Hostility         | <input type="checkbox"/> Difficulty Sleeping in Own Bed |
| <input type="checkbox"/> Suicidal Thoughts/Statements      | <input type="checkbox"/> Very Active                    |
| <input type="checkbox"/> Difficulty with Authority Figures | <input type="checkbox"/> Easily Distracted              |
| <input type="checkbox"/> Often in Trouble                  | <input type="checkbox"/> Has Conflicts with Peers       |
| <input type="checkbox"/> Argumentative                     | <input type="checkbox"/> Doesn't Follow Directions      |
| <input type="checkbox"/> Other (please describe): _____    |   |

List and describe any history of emotional disorder(s) in your child's biological family:

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List and describe any significant life events (e.g. divorce, death in family, etc.):

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How does your child function at school (i.e. grades, with peers with teachers)?

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List and describe your child's current or historical physical problems (e.g. weight gain, headaches, hypoglycemia, stomachaches, etc.):

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List any medication(s) and dosage your child is currently prescribed: \_\_\_\_\_

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Prescribing Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

What are your child's strengths and hobbies? \_\_\_\_\_

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List your three primary treatment goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

If there is anything else you would like your child's therapist to know please add it here:

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