

## NEW CLIENT INTAKE FORM (CHILD/ADOLESCENT)

*Please provide the following information and answer the questions below; print the form and bring it to your first session. Please note that the information you provide here is protected as confidential information.*

Child's Name: \_\_\_\_\_ (LAST, FIRST, MI)

Name of parent/guardian: \_\_\_\_\_ (LAST, FIRST, MI)

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ Gender: Male Female

Address: \_\_\_\_\_  
(STREET NUMBER)

\_\_\_\_\_  
(CITY) (STATE) (ZIP CODE)

Home Phone: (\_\_\_\_) \_\_\_\_\_ May we leave a message? Yes No

Cell/Other Phone: (\_\_\_\_) \_\_\_\_\_ May we leave a message? Yes No

E-mail: \_\_\_\_\_ May we email you? Yes No

**\*Please note that e-mail correspondence is not considered to be a confidential medium of communication.**

Referred by (if any): \_\_\_\_\_

Has your child previously received any type of mental health services?

No Yes, previous therapist/practitioner: \_\_\_\_\_

Is your child currently taking any prescription medication?

No Yes, please list: \_\_\_\_\_

Has your child ever been prescribed psychiatric medication?

No Yes, please list and provide dates: \_\_\_\_\_

### FAMILY INFORMATION

1. Please complete the following information for family members living in the home:

Name	Age	Sex	Rel'p to child	Education	Describe the Relationship

2. Please complete the following information for family members living outside of the home:

Name	Age	Sex	Rel'p to child	Education	Describe the Relationship

3. Is your child:    Adopted                      Step-child                      Foster child                      Biological child

4. Are the parents:   Married                      Separated                      Divorced                      Deceased

5. What is the primary language spoken in the home? \_\_\_\_\_

6. Has any family member experienced any major changes or stressful events in the recent past?

No      Yes, please explain: \_\_\_\_\_

**GENERAL HEALTH AND MENTAL HEALTH INFORMATION**

1. How would you rate your current child's physical health?

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

Please list any specific health problems you are currently experiencing:

2. How would you rate your child's current sleeping habits?

Poor                      Unsatisfactory                      Satisfactory                      Good                      Very good

Please list any specific sleep problems your child is currently experiencing: \_\_\_\_\_

3. Has your child been known to drink alcohol?  No  Yes, \_\_\_\_\_

4. Has your child been known to use recreational drugs?  No  Yes, \_\_\_\_\_

5. Has your child experienced any significant life changes or stress recently?

6. Does your child suffer from any neurological, genetic, or other chronic illness or condition?    No

Yes, please explain: \_\_\_\_\_

7. Has your child ever felt like life is not worth living or expressed a desire to harm him/herself?  No

Yes, please explain \_\_\_\_\_

**EDUCATIONAL INFORMATION**

1. Name of child's current school: \_\_\_\_\_
2. Type of school: Public Private Other: \_\_\_\_\_ 3. Grade/level: \_\_\_\_\_
3. What grades does your child receive? \_\_\_\_\_
4. Have there been any significant recent changes in grades or behaviors at school? No Yes,  
please explain: \_\_\_\_\_

**SOCIAL & RECREATIONAL INFORMATION**

1. Does your child have friends? No Yes      2. Does your child have a best friend? No Yes
3. What types of activities does your child enjoy? \_\_\_\_\_
4. Does your child currently belong to any organized clubs, groups or sports? No Yes, \_\_\_\_  
\_\_\_\_\_
5. What do you feel are your child's most positive behavioral characteristics? \_\_\_\_\_  
\_\_\_\_\_
6. What behaviors concern you most? \_\_\_\_\_  
\_\_\_\_\_
7. Does your child consider him/herself to be spiritual or religious? No Yes, faith or belief:  
\_\_\_\_\_

**FAMILY MENTAL HEALTH HISTORY:**

*In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc...).*

	<b><u>PLEASE CIRCLE</u></b>	<b><u>LIST FAMILY MEMBER(S)</u></b>
Alcohol/Substance Abuse	No Yes	_____
Anxiety	No Yes	_____
Depression	No Yes	_____
Domestic Violence	No Yes	_____
Eating Disorders	No Yes	_____
Obesity	No Yes	_____
Obsessive Compulsive Behavior	No Yes	_____
Schizophrenia	No Yes	_____
Suicide Attempts	No Yes	_____

What would you like to accomplish in therapy? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIMITS OF CONFIDENTIALITY**

*Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:*

**Duty to Warn and Protect:** When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults:** If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances:** Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minors/Guardianship:** Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**Insurance Providers** (when applicable): Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

\_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_  
**Today’s Date**

\_\_\_\_\_

**Parent/Guardian Printed Name**