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# Client Intake Information (Child)

Date: _______________

**Demographic Information**

Client Name: ___________________________ _____________________ ________________________________
First Middle Last

Mother's Name: ___________________________ Father's Name: ___________________________________

Client's Birth date: _________________Age: _______ Gender: _____ Male_____ Female

Street Address: ______________________________________________________________________________

_____________________________________________________________________________________________

Home Phone: ____________________________ Parent/Guardian Cell Phone: _______________________

Parent/Guardian Work Phone: _________________ Parent/Guardian Email: _________________________

How do you prefer to be contacted? _______________________________________________________

Ethnic Background: ___ African American ___ Asian/ Pacific Islander ___Caucasian/White
___ Hispanic/ Latino(a) ___ Native American ___ Other

**Personal Information**

Briefly describe the presenting problem (Precipitating factors leading to seeking counseling):
_____________________________________________________________________________________________
_____________________________________________________________________________________________

What strategies have been attempted to address this problem? How much did those strategies help?
_____________________________________________________________________________________________

When is the presenting problem less likely to occur? What typically helps the child feel better?
_____________________________________________________________________________________________
_____________________________________________________________________________________________

What are the child's strengths and interests?
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Are there any medical/mental health diagnoses for the child (if yes, please name diagnosis and age of diagnosis):_________________________________________________________________________

School the client is currently attending: ______________________________ Grade: ____________

Does the client currently have an IEP or 504 Plan? ___ Yes ___ No (If Yes, please circle which type of plan is currently being used)

Please describe any problems your child is having in school (socially, academically, behaviorally, etc.) ______________________________________________________________________________
______________________________________________________________________________

**Health**:

Last Doctor's visit_______ (Date) Physician's name:__________________ Phone ____________

Medications and Reasons for Medications:
______________________________________________________________________________
______________________________________________________________________________

Briefly describe the client's medical health, problems, and/or any hospitalizations:
______________________________________________________________________________
______________________________________________________________________________

Please describe any significant pregnancy/birth history:
______________________________________________________________________________
______________________________________________________________________________

Allergies: ______________________________________________________________________

Please describe any trouble the client has sleeping.
______________________________________________________________________________
______________________________________________________________________________

Is the client currently under psychiatric care, alcohol, or drug treatment? If yes, give name of doctor and brief explanation______________________________________________________________
______________________________________________________________________________

Describe if any, current and past use of alcohol, caffeine and/or smoking ____________________
______________________________________________________________________________

Describe any past counseling_______________________________________________________

**Household Status:**

Parental Marital Status: ___ Married ___ Single ___ Separated ___ Divorced ___ Widowed

The client is currently living with:
___ Both Parents ___ Mother ___ Father ___Guardian(s) ________________

Is the client adopted? ___ Yes ___ No

Names/Ages of siblings:_____________________________________________________

Please describe child's relationship with each parent: _______________________________________
______________________________________________________________________________

Please describe any problems that the child experiences at home (arguing, not listening, etc.) ______
______________________________________________________________________________

Parental Employment status:
Mother employed? ____ Yes ____ No Job Title: ________________
Father employed? ____ Yes ____ No Job Title: ________________

Please describe any family history of learning or mental health problems (e.g. learning disability, depression, addiction, etc.) ____________________________________________________________
______________________________________________________________________________

I ____________________ do sign that the information given today is true and accurate information.

______________________________ ______________________________
Parent's Signature Therapist's Signature

______________________________ ___________________________
Parent's Printed Name Date


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