Child and Adolescent Intake Form

Client Name: _____ Date: _____

DOB: _____ Age: _____ Gender: _____

Parent(s)/guardian(s) Name(s): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____

Phone Number(s): _____

Is it ok to leave a voicemail? *YES* *NO*

Is it ok to text about scheduling? *YES* *NO*

What are the 3 biggest concerns you have for your child right now? How long have each been going on? Put them in order of importance:

1. _____
2. _____
3. _____

What solutions (helpful or unhelpful) have you tried to resolve the above concerns?

_____

_____

What are your hopes or expectations from therapy and the therapist?

_____

_____

If you had a crystal ball and were able to look into the future you will say therapy has been worth it because (list concrete changes you would like to see):

_____

_____

_____

How long do you think therapy will need to last to achieve the changes/goals you want? _____

List 5 of your child's strengths:

_____

_____

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313 West Beltline Highway, Suite #204, Madison, WI, 53713

Has your child ever received psychiatric services before? YES NO

Does your child have any allergies? _____

Is your child presently under a physician's care? If so, for what?

_____

_____

Has your child ever had suicidal ideation or planned to hurt their self? YES NO
If yes, please explain: _____

Has your child experienced significant trauma? If so, please explain briefly:

_____

_____

What school does your child attend? In which grade? _____

How is your child doing in school? Does your child receive specialized academic services?

_____

_____

Who lives at home with the child? Please include if there are multiple homes, and pets.

_____

_____

List 3 or more strengths of your family:

_____

_____

How do you envision your involvement in your child's therapy?

_____

Is there anything else that you think is important for us to know about your child?

_____

_____

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