



**CHILD/ADOLESCENT INTAKE INFORMATION**

**Referred Child's Siblings: (including stepsiblings)**

			<u>Living in Home?</u>	
Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____

**Others living in home:**

Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____
Name _____	Age ____	Birth date _____	Yes ____	No ____

**MEDICAL PERSONNEL OR AGENCIES CURRENTLY WORKING WITH FAMILY:**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Providing: \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Providing: \_\_\_\_\_

Name of Child's Physician: \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency, whom may we contact? Name \_\_\_\_\_  
Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**Presenting Problems:**

Briefly describe why you are here: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you want to accomplish as a result of your child's and/or your family's therapy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Therapist notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

