

CHILD/ADOLESCENT INTAKE INFORMATION

FAMILY IDENTIFYING INFORMATION SHEET

Today's Date: _____

Name Child/Adolescent: _____ Birth date: _____ Age: _____

Address: _____
Street or P.O. Box City State Zip Code

Grade in School: _____ School: _____

Teacher: _____ Counselor: _____

Referred by: _____

PARENTS:

Mother:

Name: _____ Birth date: _____ Age: _____
Relationship to child: Biological _____ Step _____ Adoptive _____ Foster _____ Other _____
Address: _____ Present Relationship Status:
Married _____ Date _____
Divorced _____ Date _____
Employer: _____ Separated _____ Date _____
Job Title: _____ Widowed _____ Date _____
Work Hours: _____ Committed Relationship _____
Work Phone: _____ Never Married _____
SS # _____

Father:

Name: _____ Birth date: _____ Age: _____
Relationship to child: Biological _____ Step _____ Adoptive _____ Foster _____ Other _____
Address: _____ Present Relationship Status:
Married _____ Date _____
Divorced _____ Date _____
Employer: _____ Separated _____ Date _____
Job Title: _____ Widowed _____ Date _____
Work Hours: _____ Committed Relationship _____
Work Phone: _____ Never Married _____
SS # _____

Other: (if applicable):

Name: _____ Birth date: _____ Age: _____
Relationship to child: Biological _____ Step _____ Adoptive _____ Foster _____ Other _____
Address: _____ Present Relationship Status:
Married _____ Date _____
Divorced _____ Date _____
Employer: _____ Separated _____ Date _____
Job Title: _____ Widowed _____ Date _____
Work Hours: _____ Committed Relationship _____
Work Phone: _____ Never Married _____
SS # _____

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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 ____

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: _____

