Date _______________

Intake Form

Child's Name _______________________ Date of birth _________________

Parent/Legal Guardian ____

Address ____

City ______________________ Zip ___________________

Primary phone ____________________ Okay to leave vm: ☐ Yes ☐ No

Secondary phone _________________ Okay to leave vm: ☐ Yes ☐ No

Email____

Other Involved adult: _________________ Relationship: ________________

Will this adult be involved in treatment? _______________________________

Is it okay to send mail to this address? ☐ Yes ☐ No

Is it okay to contact you via email, strictly for the purposes of scheduling? ☐ Yes ☐ No

In order to protect your privacy, I typically do not identify myself as a counselor when I call. I generally return phone calls within 24 hours of receiving them. If you have not heard back from me in a reasonable time, please attempt to call me again.

Briefly describe the concerns that have brought you here. _________________________

____

____

____

What do you hope to achieve in therapy? _________________________________

____

____

Please tell me about your child's strengths. ______________________________

____

____

Please tell me about your child's interests. _______________________________

____

____

Child's History

Has your child previously seen a therapist? _____ When? ________________________

With whom? _________________________ For what issue/s? ______________________

____

What was effective about that treatment? _______________________________________

____

____

What was ineffective about that treatment? _____________________________________

____

____

Current School _________________________________ Current Grade _______________

Previous Schools ____

Are there any concerns regarding school or school performance? If so, please explain.

____

____

____

Has the child always lived with you? ____

Are there other children in the home? Have there ever been other children in the home?

____

Are there any current medical concerns for your child? If so, explain.________________

____

____

Please list current medications (including non-herbal).

Name of medication	Start Date	Dosage	Comments

Have your child ever been hospitalized for physical or mental health reasons? ________

Briefly describe with dates. ____

____

____

Behavior Checklist

	Yes	No	Comments
My child sleeps well			
My child has meaningful friendships			
My child is engaged with school			
My child participates in extracurricular activities			
My child displays acts of self-harm			
My child can be aggressive towards peers			
My child can be aggressive towards adults			
My child argues a lot			
My child has excessive fears			
My child often has physical aches or pains			
My child responds well to discipline			
My child appears nervous			
My child lies to avoid responsibility			
My child takes things that are not his/hers			
My child struggles with maintaining attention			
My child shows interest in learning new things			

How did you hear about me and/or The Counseling Collaborative? ___________________
____

Are you interested in a counseling group for your child? ______________________________
If so, for what issue/s? ____
____

Is there anything else you would like for me to know? ________________________________
____
____
____
____
____
____