



**CHILD INTAKE FORM**

**CONFIDENTIAL**

Today's Date \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of birth \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone number (cell): \_\_\_\_\_ (home): \_\_\_\_\_ (work): \_\_\_\_\_

Email address: \_\_\_\_\_

May I leave a voicemail on your cell or home number? Yes \_\_\_\_ No \_\_\_\_

Additional Parent Contact (name): \_\_\_\_\_ (number): \_\_\_\_\_

**Insurance:**

Policy Provider: \_\_\_\_\_ Policy No. \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

How did you hear about our counseling services?

- Pre-service slide     Service     Flyer     Guest Services Desk     a Life Group  
 Website     Friend     or Other?

**Parent's Work / Educational History:**

Are you employed?  FT     PT     Unemployed

What type of work do you do? \_\_\_\_\_

Are you a student? Yes \_\_\_\_ No \_\_\_\_ If yes, where? \_\_\_\_\_

**Present area of Concern:**

What is the primary reason that brings you here today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long has this been a problem for you/(your child)? \_\_\_\_\_

What do you hope to accomplish through counseling? \_\_\_\_\_  
\_\_\_\_\_

What have you done already to deal with the difficulties? \_\_\_\_\_

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Please tell me some of your child's strengths? \_\_\_\_\_

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Have you received counseling in the past? (yes or no) If yes, briefly discuss the nature, duration and outcome. \_\_\_\_\_

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Current School \_\_\_\_\_ Current Grade \_\_\_\_\_

Previous School(s) \_\_\_\_\_

Are there any concerns in relation to school or school performance? If so, please explain.

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With whom (relation) does the child currently reside and have they always lived with them?

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Are there other children in the home? \_\_\_\_\_

If no, have there ever been other children in the home? \_\_\_\_\_

Please list names and ages of other children:

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

### **Physical History**

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

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Please list any current medications:

Name of Medication	Start Date	Dosage	Comments

Has your child ever been hospitalized for physical or mental health reasons? \_\_\_\_\_

Briefly describe with dates: \_\_\_\_\_

\_\_\_\_\_

	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 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			

**Spiritual History**

Briefly describe your thoughts on your child’s understanding/relationship with God (if any):

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**Emotional Status:**

Is your child currently experiencing any strong emotions (ex. Prolonged frustration, anger, sadness)?

\_\_\_\_\_ If yes, describe \_\_\_\_\_

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Have you noticed distinct changes in your child’s personality? \_\_\_\_\_ If yes, please describe:

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Has your child ever expressed any thoughts of suicide? \_\_\_\_\_ If so, when \_\_\_\_\_

Do you believe that he/she has any thoughts of suicide now? \_\_\_\_\_

**Interests:**

Please describe your child’s interests: \_\_\_\_\_

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**Family History:**

Please check off all that apply:

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

- |                        |                                 |
|------------------------|---------------------------------|
| _____ Bipolar disorder | _____ Schizophrenia             |
| _____ Depression       | _____ Post-traumatic stress     |
| _____ Anxiety          | _____ Alcohol abuse             |
| _____ Anger            | _____ Other substance abuse     |
| _____ Violence         | _____ Suicide/Suicidal thoughts |

If yes, briefly describe:

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Has any family member been treated with a psychiatric medication? Yes \_\_\_\_ No \_\_\_\_

If yes, who was treated, what is their relation to your child, what medications did they take (if known), and how effective was the treatment?

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**Other**

Is there anything else that is important for me as your therapist to know, and that you have not written about on any of these forms? If yes, please discuss here:

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# COUNSELING AGREEMENT

As part of the counseling process, I understand that I may be required to follow through with homework exercises such as reading, changing behaviors, praying, or other initiatives that will serve my best interest. Ultimately I understand that I am entirely responsible for my own actions and I will always make my own final decisions regarding counseling. \_\_\_\_\_ Initial

I further understand that my progress will be a direct result of my honesty, the work that I will put into resolving my issues and my willingness to move forward even if it is painful and difficult. \_\_\_\_\_ Initial  
I understand that my communication with my counselor is strictly confidential and will not be released to anyone without my consent, unless I am in violation of codes of abuse – physical or sexual, a harm to myself or others. By law, my counselor is required to report such exceptions to the proper authorities in order to protect myself and/or those in danger. \_\_\_\_\_ Initial

Additionally, my counselor may consult with another therapist regarding my case. This therapist will also be bound by the same confidentiality laws, that being said, my name and identity will remain anonymous. \_\_\_\_\_ Initial

I understand that I will pay in full for each session (**50 minutes**). The rate is \$95/session. I understand that I will pay the **\$95 cancellation fee** for appointments not cancelled with **24 hours notice**. You may notify your therapist by phone to cancel or reschedule. \_\_\_\_\_ Initial (954)755-7767 x105 or (954)282-9648

Finally, although we meet in a church setting, I understand that if I see my counselor outside of the counseling sessions she will not discuss my sessions outside of my scheduled visits. This is protect the boundaries of the counselor/client relationship. \_\_\_\_\_ Initial

I acknowledge that I have read this agreement in its entirety and agree to the conditions set forth.

\_\_\_\_\_ Date \_\_\_\_\_  
(Client or Parent Guardian Signature)

\_\_\_\_\_ Printed Name

\_\_\_\_\_ Printed Name