



Intake Form (Minor)

Patient name: _____

Date completed: ___/___/___ Patient age: _____ DOB: ___/___/___ Gender: _____

Address: _____
(Street Address) (City/State/Zip)

Person(s) completing this form: _____ Relationship to patient: _____

Mother's name: _____ Birthdate: ___/___/___

Best contact number : (____) _____ - _____ Primary Contact? Yes / No May I leave a message? Yes / No

Father's name: _____ Birthdate: ___/___/___

Best contact number : (____) _____ - _____ Primary Contact? Yes / No May I leave a message? Yes / No

Parents are currently: ___ Married ___ Divorced ___ Remarried ___ Never Married ___ Other

Stepparent's name: _____ Birthdate: ___/___/___

Best contact number : (____) _____ - _____ Primary Contact? Yes / No May I leave a message? Yes / No

Who suggested that you come see me, or how did you find me? _____

If you found me online, please provide site: _____

Why are you bringing your child to therapy now? _____

Health and Development

List all health problems, including serious illnesses, hospitalizations, surgeries, head injuries, important accidents and injuries, eating patterns, exercise, sex, allergies, and other medical conditions: _____

Were developmental milestones (crawl, walk, talk, etc.) met on time, early, late, very late? _____

Any problems with learning? _____

Any issues with sleeping? _____

Any changes in appetite? _____

List any previous therapy or hospitalization for emotional, psychiatric, or behavioral issues:

Therapist(s) seen (name and title)	Type of treatment and purpose of therapy	Dates of Therapy	Response to therapy, reasons stopped

Is there a history of physical, sexual, or emotional abuse, or any significant trauma? _____

Any family history of any mental health, emotional, or behavioral issues? _____

Has the client taken any psychiatric medication for emotional, psychiatric or behavioral issues?

Medication/Dosage	Reasons Taken	Physician (name)	Dates taken	Response to medication, side effects?

School History

Currently attends (circle one): Public school Private school Virtual school Homeschooled Other

Name of school: _____ Current or most recent grade: _____

Does the client have an IEP or 504 Plan? If so, please explain: _____

Any areas of academic concern? _____

Has the client ever been retained or skipped a grade? _____

Has the client ever been suspended or expelled from school? For what reason? _____

Social History

Who lives with the client? (names and relationship) _____

How well does the client get along with parents, siblings, and peers? _____

Compared to others of the client's same age, the client has (circle one):

No friends Fewer friends Average number of friends More friends

Does the client have a tendency to have friends who are: Younger Same age Older

Any concerns about client's social relationships? _____

List all hobbies and recreation (sports, music, TV, toys, technology): _____

Is the client currently involved in any legal matters? If so, please explain. _____

Other

Is there anything else I should know that doesn't appear on this page or other forms, but that is or might be important? _____

Signature of Parent or Guardian

Date