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

May I send automatic text appointment reminders? Yes / No

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

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

May I send automatic text appointment reminders? 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