Julie Laraway, LMFT
Licensed Marriage & Family Therapist License No.: MFC 41695
25050 Peachland Avenue, Suite 250
Newhall, CA. 91321
(661) 236-8925

Child / Adolescent Intake Form

Please answer the following questions to the best of your knowledge/ability.
All information provided is protected as confidential information

Child's Name: ____________________ Date of Birth: ____________________

Child's Gender: ☐ Male ☐ Female Social Security No.: ____________________

Name of School: ____________________ Current Grade: ____________________

Name of parent(s)/guardian(s): ____________________

Parent's Marital Status: ☐Never married ☐Domestic Partnership ☐ Married ☐Separated ☐ Divorced ☐Widowed

Address (Primary Residence): ____________________
(street & number) (city) (state) (zip)

Additional address, if applicable: ____________________
(street & number) (city) (state) (zip)

May I mail to you at this address? ☐ Yes ☐No, please send mail to ____________________

Home Phone: ( ) __________

Mother/Guardian: Work Phone: ( ) __________ Cell Phone: ( ) __________

Father/Guardian: Work Phone: ( ) __________ Cell Phone: ( ) __________

May I contact you and leave messages at these numbers? ☐ Yes ☐ No, please contact me via ____________________

Email: ____________________ May I email you? ☐ Yes ☐ No
*please note: email correspondence is not considered to be a confidential mode of communication

Mother's Employer: ____________________ Occupation: ____________________

Father's Employer: ____________________ Occupation: ____________________

GENERAL HEALTH INFORMATION:

Child's Physician's Name: ____________________ Phone: ( ) __________

Address: ____________________ Last Appt: __________

Is child currently experiencing any health problems? ☐No ☐ Yes
If yes, please describe: ____________________

Is child currently seeing a psychiatrist? ☐No ☐ Yes
If yes, Name and Phone Number: ____________________

Is child taking any prescription medications? ☐No ☐ Yes
If yes, please list: ____________________

Has child ever been prescribed psychiatric medication? ☐ No ☐ Yes
If yes, please list name(s) and dates: ____

Has child previously received any type of mental health services (i.e., psychotherapy)? ☐ No ☐ Yes
If yes, dates(s) & reason for treatment:____
____

Has child ever been hospitalized for emotional or mental reasons? ☐No ☐ Yes
If yes, please describe (i.e., dates, reasons, location: ________________________________
____

How would you rate child's current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems child is currently experiencing: ____________________
____

How would you rate child's current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems child is currently experiencing: ____________________
____

How many times per week does child generally exercise? ________________________________

What types of exercise does s/he participate in? ________________________________

List any extra-curricular activities child currently participates in ____________________
____

Please list any difficulties child experiences with his/her appetite or eating patterns: ____________
____

MENTAL HEALTH INFORMATION:

1. Is child currently experiencing overwhelming sadness, grief or depression?
☐No ☐Yes If yes, for approximately how long and any known trigger(s) ? ____________
____
____

2. Is child currently experiencing anxiety, panic attacks or have any phobias?
☐No ☐Yes If yes, when did s/he begin experiencing this and any known trigger(s) ? ________
____
____

3. Is child currently experiencing any chronic pain?
☐No ☐Yes If yes, please describe: ________________________________

4. To you knowledge, does child drink alcohol more than once a week? ☐No ☐Yes

5. To your knowledge, how often does child engage in recreational drug use?
☐ Daily ☐Weekly ☐Monthly ☐Infrequently ☐Never

6. To your knowledge, is child currently in a romantic relationship? ☐No ☐ Yes
If yes, for how long? ________________

7. What significant life changes or stressful events has child experienced recently ________________________
____
____
____
____

FAMILY MENTAL HEALTH HISTORY:

In this section below please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to child in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	Yes / No	________________
Anxiety	Yes / No	________________
Depression	Yes / No	________________
Domestic Violence	Yes / No	________________
Eating Disorder(s)	Yes / No	________________
Obesity	Yes / No	________________
Obsessive Compulsive Behavior(s)	Yes / No	________________
Schizophrenia	Yes / No	________________
Suicide Attempts/Completion	Yes / No	________________

Family History continued:

Child's Family of Origin:
Mother: ☐ alive ☐ deceased (date: _________) Father: ☐ alive ☐ deceased (date: ________)
Child's siblings (age and gender): ____
____

History of death(s) child has experienced within circle of family and/or friends: ________________________
____
____

ADDITIONAL INFORMATION

1. What is child's grade level: _______ Does s/he enjoy school? ______________________________
To your knowledge, is there anything stressful about school (i.e., social/peers, academics, etc.)?
____
____

2. Do you consider yourself and child to be spiritual or religious? ☐ No ☐ Yes
If yes, describe your faith or belief: ____
____

3. What do you consider to be some of your child's strengths? ____________________________________
____
____
____

4. What would you like your child to accomplish out of his/her time in therapy? ____________________________
____
____
____

5. Do you have any specific fears or concerns regarding your child's treatment? ____________________________
____
____
____

6. How were you referred to me? ____
____

Person(s) to contact in case of emergency:

Name: ______________________ Phone Number: ( ) ____________________ Relationship: ______________

Name: ______________________ Phone Number: ( ) ____________________ Relationship: ______________