CHILD/ADOLESCENT INTAKE FORMS
PARENTAL QUESTIONNAIRE
PATIENT INFORMATION

******You may type your answers right in each box before printing.******

Child/Teen's Name:	Date of Birth:

Age:	Sex:	Race:
School:		Grade:

Religious affiliation:

Mother and Father's Name:

Address:

Home phone:	Cell phone:	Work phone:

Who is the child currently living with?

Referred by: May I send a thank-you note? If yes, please provide an address or phone number for the person:

Please provide a brief summary of the situation/symptoms for which you are seeking help: What would you like to see accomplished in your child's counseling:

Has your child received previous counseling?	If so, when and where?

MEDICAL HISTORY

Please list any current medical problems/medications:

Past medical/developmental/educational problems/medications:

Allergies?

Pediatrician's Name:

FAMILY HISTORY

Family Structure: (who lives in the current household/relationship to the child)

Family Development: (marriages, separations, divorces, deaths, traumatic events/losses)

Current Marital Situation:

Mother's History:

Age: Work situation: School: highest grade completed:

Learning/Behavior problems:

Marriages (How many? How long?)

Medical problems:

Childhood atmosphere (family position, abuse, illness, etc)

Please specify any mental health treatment, alcohol/drug abuse history, psychiatric treatment, suicide attempts, hospitalizations:

Father's History

Age: Work situation:

School: highest grade completed:

Learning/Behavior problems:

Marriages (How many? How long?)

Medical problems:

Childhood atmosphere (family position, abuse, illness, etc)

Please specify any mental health treatment, alcohol/drug abuse history, psychiatric treatment, suicide attempts, hospitalizations:

If child is adopted, please give pertinent information:

Siblings (names, ages, problems, strengths, relationship to client):

Name	Age	Relationship	Problems	Strengths

Family Stressors (current factors that are a source of stress in the family):

Please list any developmental problems (feeding, sleep, anxiety, motor/language/social developmental problems, toilet training, etc.)

Name of person filling out form:
Relationship to child or adolescent: