Child Intake Form

Welcome to Epiphanye Counseling Services! I look forward to providing you with quality and effective services. Please provide the following information and answer the questions below. The information you provide will help me to understand your situation and help me best help you. Please note that the information you provide on this form is confidential. Please fill out the form and complete prior to the session.

Today's Date: _____________

Type of Services being sought (check all that apply):

□ Individual □ Couple/Marital □ Family □ Group

Referred by: ____

General Information:

Name: ____

(Last) (First) (Middle Initial)

Name of parent/guardian

____

(Last) (First) (Middle Initial)

Birth Date: ________/________/________ Age: Gender: □ Male □ Female

Marital Status:

□ Single □ Partnered □ Married □ Separated □ Divorced □ Widowed

Address: ____

(Street and Number)

____

(City) (State) (Zip)

Home Phone: ________________________ May we leave a message? □Yes □ No

Cell/Other Phone: ______________________ May we leave a message? □Yes □ No

E-mail: ____________________________________ May we send you our newsletter? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication. ECS has secure email for those who would like to communicate through email.

Would you like appointment E-mail reminders? □Yes □ No

May we send material/information to your home? □ Yes □No

Please provide a security question and answer to transmit sensitive information securely via email____

Other Household (if applicable):

Address: ____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ________________________ May we leave a message? □Yes □ No

Cell/Other Phone: ______________________ May we leave a message? □Yes □ No

E-mail: ____________________________________May we send you our newsletter? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication. ECS has secure email for those who would like to communicate through email.

Would you like appointment E-mail reminders? □Yes □ No

May we send material/information to your home? □ Yes □No

Emergency Contact

Name: _______________________________________ Rel. to Client_____________________________

Phone: ____

Names of other individuals living in Household:

Last, First Name	Relation to Client	Age/Birth Date	Highest Grade Completed

What is your annual household income (for clients using sliding fee scale rate)? ____________________

What are your primary concerns that bring you here?

1. ____

2. ____

3. ____

What are your goals for counseling?

1. ____

2. ____

3. ____

What is your primary language? ____

Race: ____

Cultural Considerations____

Religion: ____

What special accommodations do you need (if applicable) ______________________________________

____

Mental Health and Social History

Has he/she previously received any type of mental health services (Psychotherapy, Psychologist, Psychiatric services.)? No□ If yes, please indicate the problem/condition and dates of treatment:

____

____

____

Is he/she currently taking any prescription medications? Yes □ No □ If yes, please list:

____

____

Is he/she currently taking prescribed psychiatric medications? Yes □ No □ If yes, please list:

____

Is he/she been previously prescribed psychiatric medication? Yes □ No □ If yes, please list:

____

____

Does he/she have or have he/she had any suicidal/homicidal thoughts/attempts? Yes □ No □ If yes, please describe:

____

____

Does he/she engage or has he/she engaged in self-injurious behavior(s)? Yes □ No □ If Yes, please describe:

____
____
____

Has he/she been in trouble at school (expulsion, suspension etc.)? Yes □ No □ If yes, please explain:

____
____
____

Medical and Health History

Primary Physician:

____

Primary Physicians Address:

____

Primary Physicians Phone: ______________________Date of Last Exam___________________________

Please List Allergies (if any) ____

____

Is it okay to contact his/her primary physician to coordinate services and provide your child with quality and effective care? Yes □ No □

Please list any specific health problems he/she has had previously or is currently experiencing:

____
____
____

Has he/she been treated for a medical problem(s) and/or disability?

Name Condition Dates of treatment

____
____
____

Substance Abuse

Has he/she had any trouble with alcohol or other substances? Yes □ No □ If yes, please explain:

____

____

____

Abuse History

Has he/she experienced physical, sexual or emotional abuse? Yes □ No □ If yes, please explain:

____

____

____

Legal History

Has he/she been involved with the legal system (probation, jail, prison, DUI etc.)? Yes □ No □ If yes, please explain:

____

____

____

Family Mental, Social & Health History

Has anyone in the family attended therapy previously or is currently in treatment? Yes □ No □ If yes, please explain:

Name Reason for Treatment Dates of treatment

____

____

____

Has anyone in the family been a victim or perpetrator of child/elder abuse (physical, sexual, emotional, neglect), domestic violence, rape or related violent behaviors? Yes □ No □ If yes, please explain:

Name Type of abuse/trauma Dates of treatment

____

____

____

Has anyone in the family have/had suicidal thoughts/attempts? Or engage (d) in self-injurious behaviors? Yes □ No □ if yes, please explain:

Name Type of problem Dates of treatment

____

____

____

Has anyone in the family been involved with the legal system (probation, jail, prison, DUI etc.)? Yes □ No □ If yes, please explain:

Name Reason Dates of treatment

____

____

____

Does/has anyone in the family have/ had trouble with alcohol or other substances? Yes □ No □ if yes, please explain:

Name Substance Used Frequency/Amount

____

____

____

Personal Strengths, Interests and Relationships

What are his/her strengths?

____

Please list his/her support system(s)?

List any groups, hobbies, interests:

____

____

Is there anything else that you would like me to know? Please explain

____

____

I hereby represent that the above information is accurate, true and complete. I further certify that I am the parent and/or legal guardian of the child (children) listed on this intake and I am legally able to make decisions on the child's behalf. By entering my name below, I am indicating my intent to electronically sign this acknowledgement, and I understand that this has the same effect as signing a paper acknowledgement by hand.

Signature: ____ Rel. to Client. _____________________

(Parent/ Legal Guardian) and Date