

INTAKE INFORMATION FORM – CHILD / ADOLESCENT

(PLEASE PRINT)

Appointment Date and Time:	For Therapist Use Only:
Appointment Date: ____ / ____ / ____	Diagnosis: _____
Time: _____	IP: _____
Therapist: _____	Type Code: <input type="checkbox"/> I <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G <input type="checkbox"/> E
Office: _____	Payment Type: <input type="checkbox"/> Insurance <input type="checkbox"/> Private Pay

Important: Each person going into the session should complete his/her own intake form.
Parents *should not* complete the form in their child's name.

Your Name: _____ Date of Birth: _____ Age: _____ Gender: _____ Grade: _____
Boy / Girl _____

Your brothers / sisters: _____
_____ Boy / Girl _____
_____ Boy / Girl _____
_____ Boy / Girl _____

Parent(s) you live with: _____ Home Phone: _____

Address: _____

City, State, ZIP: _____

Other Parent(s): _____

Address: _____ City, State, ZIP: _____

_____ Phone: _____

Your School and Activities:

School: _____

Guidance Counselor's Name: _____

What are your favorite activities?

How many good friends do you have? _____

Medical Information:

Doctor's Name: _____

Do you have any allergies? _____

Are you taking any medications? _____

SAMARITAN COUNSELING CENTER OF THE CAPITAL REGION

Help and Hope for your Mind and Spirit

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What are you here to work on?

How has this affected your ... (1 = Not at all, 5 = Very Much)

Parents / Siblings	1	2	3	4	5
Schoolwork	1	2	3	4	5
School Attendance	1	2	3	4	5
Friendships	1	2	3	4	5
Health	1	2	3	4	5
Worry Level	1	2	3	4	5
Feelings	1	2	3	4	5
Eating Habits	1	2	3	4	5
Sleep	1	2	3	4	5
Concentration/Restlessness	1	2	3	4	5
Anger	1	2	3	4	5
Relationships w/ Opposite Sex	1	2	3	4	5

Is there now or has there been any substance abuse in your family? Yes No

Relationship: _____

Do you have concerns about abuse? Yes No

- Physical
- Sexual
- Emotional
- Substance

Have you ever hurt yourself on purpose? Yes No

Do you ever think of committing suicide? Yes No

Have you ever attempted suicide? Yes No When? _____

Do you presently have suicidal thoughts? Yes No

Do you drink alcohol? Yes No How many times per week? _____

Do you smoke cigarettes? Yes No How many times per day? _____

Have you had previous therapy (here or elsewhere)?

Yes When? _____ Reason: _____

No

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