

**Youth Intake Form**

Name of Youth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male / Female

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Please list any medications your child is currently taking: \_\_\_\_\_

Please describe any medical conditions or your child I should be aware of (allergies, injuries, illnesses, etc): \_\_\_\_\_

Please describe your current household composition (names, ages, and relationship of those living with your child): \_\_\_\_\_

The reason I am seeking therapy for my child is: \_\_\_\_\_

What have you already tried to correct or resolve this problem?

What are you most concerned about?

What changes would you like to see as a result of therapy?

Please circle any of the following areas of concern, past or present:

- |                        |                          |                    |
|------------------------|--------------------------|--------------------|
| Anger Management       | Excessive Worry          | Medical Issues     |
| School Problems        | Separation Anxiety       | Bedwetting/Soiling |
| Obsessions/Compulsions | Hallucinations/Delusions | Helplessness       |
| Body Image             | Depressed Mood           | Shyness            |
| Problems Completing    | Nightmares               | Impulse Control    |
| Work Physical          | Hyperactivity            | Problems Low Self- |
| Complaints/Pain Family | Poor Concentration       | Esteem             |
| Problems Motor/Vocal   | Sexual Abuse             | Food Issues        |
| Tics Bullying/Teasing  | Self-Injurious Behavior  | Irritability       |
| Sleeping Problems      | Aggression               | Opposition         |
| Suicidal Thoughts      |                          | Distractibility    |
| Lying                  |                          | Cruelty to Animals |

Please explain anything circled above: \_\_\_\_\_

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Is your child adopted?  Yes  No

Has your child ever been or is he/she currently in foster care?  Yes  No

Explain: \_\_\_\_\_

Has your child received any previous counseling or treatment?  Yes  No

Explain: \_\_\_\_\_

Has your child experienced any form of abuse (physical, emotional, sexual)?  Yes  No

Explain: \_\_\_\_\_

Has your child experienced any significant trauma or losses?  Yes  No

Explain: \_\_\_\_\_

Does your child have difficulty at school or daycare?  Yes  No

Explain: \_\_\_\_\_

Does your child generally get along with other children his/her own age?  Yes  No

Does your child generally get along with adults?  Yes  No

Does your child have unusual eating patterns?  Yes  No

Explain: \_\_\_\_\_

Does your child have unusual sleeping patterns?  Yes  No

Explain: \_\_\_\_\_

**Child's Family History**

Current custody status/Visitation Agreement: \_\_\_\_\_

\_\_\_\_\_

Has your child experienced any divorces or separations?  Yes  No

Explain: \_\_\_\_\_

What are your main approaches to discipline? \_\_\_\_\_

\_\_\_\_\_

Which approaches to discipline have shown the most success? \_\_\_\_\_

\_\_\_\_\_

Is there a family history of any type of mental illness? \_\_\_\_\_

\_\_\_\_\_

Is there anything else that you think may be important for me to know? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_