Office of Harmony Satre, PsyD
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INTAKE FORM – CHILD AND ADOLESCENT

CLIENT INFORMATION

Name of Client_____ Date of Birth_____ Age _____
Informant_____ Today's Date_____
Address _____
Home phone _____ Cell phone_____ Work phone_____
Fax_____ Email_____
Languages spoken in home_____ Ethnicity_____
School_____ Grade_____
Social Security Number_____

LEGAL CUSTODIAN_____ **Phone**_____

PARENT/HOUSEHOLD INFORMATION

Name _____
Relationship to Client_____
Age_____
Occupation_____

Name_____
Relationship to Client_____
Age_____
Occupation_____

Other members in household

Name	Age	Relationship to child

REFERRAL INFORMATION

Referred by_____ Relationship_____

Referral questions/concerns (why is the child here today?)

_____
_____
_____
_____
_____
_____
_____
_____
_____

How bothersome are the current symptoms?

On a good day 0----------100

On a bad day 0----------100

0= not bothersome **100 = unbearable**

HEALTHCARE INFORMATION

Have you/your child sought help for this issue before? If yes, was the result?_____

_____

_____

Primary Care Doctor_____Phone_____

Other Service Providers:

Name/Service Provided (Previous Therapy, etc)	Dates	Contact Information

Current Medications: Name Dosage Duration

_____

_____

_____

_____

_____

Family Mental Health History_____

_____

_____

_____

Major Illnesses/Surgeries_____

_____

_____

_____

Allergies_____

Traumatic Events/Transitions/Recent Life Changes_____

_____

_____

_____

_____

_____ _____ _____

Completed by (Print Name) Signature Date