Today's Date: ____________________

Child Intake Form

Please provide the following information for your child and bring this form to your first appointment. If you are in need of additional space please feel free to write on the back of this form.

Individual(s) completing this form: ____

Client Information

Child's Name (first and last): ____

Date of Birth: ___________________Gender (M/F): _________Race/Ethnicity: ___________________________

Address: ____

1 - Parent/Guardian Name: ____

Preferred number: ____May I leave a voicemail? ***Yes No***

Email: ____May I email you? ***Yes No***

2 - Parent/Guardian Name: ____

Preferred number: ____May I leave a voicemail? ***Yes No***

Email: ____May I email you? ***Yes No***

(Please note that email is not considered to be a confidential form of communication)

Parents are currently: Married Divorced Remarried Never married

Custodial Guardian (if applicable): ____

Stepparent(s) (if applicable): ____

Are you, as the parent/guardian, involved in any legal proceedings (custody disputes, divorce)?

Yes No

If yes, please explain: ____

____

Has your child been involved in the legal system? ***Yes*** ***No***

If yes, please explain: ____

____

Name/Address of financially responsible party: ____________________________

____

Family/Individuals in Your Household

Name	Age	Gender	Relationship	Living with child?
______________	____	_____	____________	***Yes*** ***No***
______________	____	_____	____________	***Yes*** ***No***
______________	____	_____	____________	***Yes*** ***No***
______________	____	_____	____________	***Yes*** ***No***
______________	____	_____	____________	***Yes*** ***No***

Family Mental Health History

Issue		*Family Member(s)*
Depression	***Yes*** ***No***	____________________
Anxiety Disorder	***Yes*** ***No***	____________________
Panic Attacks	***Yes*** ***No***	____________________
Bipolar Disorder	***Yes*** ***No***	____________________
Obsessive Compulsive Behavior	***Yes*** ***No***	____________________
Schizophrenia	***Yes*** ***No***	____________________
Alcohol/Substance Abuse	***Yes*** ***No***	____________________
Learning Disability	***Yes*** ***No***	____________________
Trauma History	***Yes*** ***No***	____________________
Domestic Violence	***Yes*** ***No***	____________________
Eating disorder	***Yes*** ***No***	____________________

Are there any family stressors that might be affecting your child? ***Yes*** ***No***

If yes, please explain: ____

____

Primary Concerns

Main reason for bringing your child in for counseling at this time:

____

____

____

Past Psychological/Psychiatric Treatment

Has your child received psychological, psychiatric, or counseling services in the past? ***Yes*** ***No***
If applicable, which type of treatment: ***Inpatient*** ***Outpatient*** ***Both***

If your child has received some form of treatment in the past, please indicate:

When: ____

Provider: ____

Reason: ____

Results: ____

Has your child been prescribed medications for psychiatric or emotional problems? ***Yes*** ***No***
If yes, please indicate:

When: ____

Medication: ____

Prescriber of the medication: ____

Reason for medication: ____

Medical Care

Clinic Name: ____

Doctor's Name: ____

Phone: ____

Address: ____

May I get a release of information in order to coordinate care with your child's doctor? ***Yes*** ***No***

General Health

Do you have any concerns about your child's physical health? Please explain:

____

____

Is your child on any medication for physical/medical issues? ***Yes*** ***No***

Have there been any changes or difficulties with your child's eating habits? ***Yes*** ***No***

If yes, please circle: Eating less Eating more Binging Restricting

Has your child experienced any weight changes in the last 1-2 months? ***Yes*** ***No***

Is your child having any trouble with his/her sleep? ***Yes*** ***No***

If yes, please describe: ____

Medical History

Did child's mother use any of the following during pregnancy *(please circle)*:

Cigarettes Alcohol Drugs Extreme Stress

If so, please specify frequency and duration: ____

List any birth complications: ____

List any medical conditions or history of medical conditions: ___________________________

____

____

Education

School: ____Grade: _________

Please describe your child's academic performance: ___________________________________

____

Does your child have any learning disorders? ***Yes*** ***No***

If yes, please explain: ____

____

Please describe your child's social interaction at school: ______________________________

____

List of Symptoms/Behaviors
Please circle any of the following that have been of concern recently.

Alcohol/drug use	Eating disorder	Oppositional
Aggression	Fatigue	Panic attacks
Anger	Frustrated easily	Phobias
Anxiety	Hallucinations	Repetitive thoughts
Bedwetting	Headaches	Sadness
Bowel trouble	Head banging	Self-harm
Bullies others	Homicidal thoughts	Sexual acting out
Bullied by others	Hurts animals	Stomach aches
Compulsive	Impulsive	Steals
Depressed mood	Irritable	Suicide attempts
Defiant	Lies frequently	Suicidal thoughts
Destructive	Low self-esteem	Withdrawn
Difficulty with friends/siblings	Mood swings	Worries excessively
Disturbed sleep	Nightmares	

Other
Do you believe that your child is suicidal at this time? ***Yes*** ***No***

If yes, please explain: ____

____

How is discipline generally handled with your child at home? ____________________

____

Describe your child's strengths? ______________________________________

____

What does your child enjoy doing (hobbies)? _____________________________

____

ERIN K. GIST, MA, LMHC, CMHS
ERIN@RENOVACOUNSELING.COM
425-502-5641

Goals
What are your child's goals for therapy?

____

____

____

____

Insurance Information

Primary Insurance Company: ____

Insurance Company (800) Number: ____

Name of Insured (Subscriber): ______________________________ Insured's DOB: ___/___/____

Relationship to Subscriber: ____________________________________ (Self, Spouse, Child, etc.)

ID Number: ____________________________ Group Number: ___________________________

Subscriber's Employer: ____ Co-Pay: $___________

Secondary Insurance Company: ____

Insurance Company (800) Number: ____

Name of Insured (Subscriber): ______________________________ Insured's DOB: ___/___/____

Relationship to Subscriber: ____________________________________ (Self, Spouse, Child, etc.)

ID Number: ____________________________ Group Number: ___________________________

Subscriber's Employer: ____ Co-Pay: $___________

I authorize Erin K. Gist, MA, LMHC, CMHS to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including co-pays, deductibles, failed and late cancelled appointments.

Signature: _______________________________________ Date: __________________________