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## INTAKE FOR CHILD THERAPY OR CONSULTATION

**Name of Child** \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

School \_\_\_\_\_ GRADE \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ Age \_\_\_\_\_

Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ Alternative Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Education \_\_\_\_\_ Marital Status \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ Age \_\_\_\_\_

Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (H) \_\_\_\_\_ Alternative Phone \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Education \_\_\_\_\_ Marital Status \_\_\_\_\_

### Others Living in Household:

Name	Age	Sex	Relation to Client
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Primary Concern: \_\_\_\_\_

Current Diagnoses (if any) \_\_\_\_\_ Past Diagnoses? \_\_\_\_\_

Current Medications (if any) \_\_\_\_\_

Prescribing Physician \_\_\_\_\_

How did you hear about us? \_\_\_\_\_