



SUZANNE NANGLE, PH.D.  
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## CHILD/ADOLESCENT INTAKE

Name of Child \_\_\_\_\_ Date \_\_\_\_\_

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

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

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

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

Phone (home) \_\_\_\_\_ Phone (alternative) \_\_\_\_\_ Email \_\_\_\_\_

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

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

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

Phone (home) \_\_\_\_\_ Phone (alternative) \_\_\_\_\_ Email \_\_\_\_\_

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

### Others Living in Household:

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

Reason(s) for Referral: \_\_\_\_\_

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

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

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



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Referral Source & Comments \_\_\_\_\_