

Intake

Name _____ Date of Birth _____ Referred by _____

What brings you (your child) to therapy at this time?

When did these concerns escalate or increase in frequency/ concern for you?

Any issues/ concerns regarding:

Eating:

Sleeping:

Social life/ Peers/ Supports/ Religion and Spirituality:

Sexual Activity/ Sexual Identity/ Gender Identity:

What is/ are your (your child's):

School/ Highest Level achieved/ Employment History:

Hobbies/ Interests:

Screen time per day or week: (electronics)

Family Composition: (Names, ages, jobs, marriages, relationships, living arrangements)

Parents:

Spouse(s)/ Significant other:

Siblings:

Children:

Other:

Major life events (Trauma, Deaths, Divorces, Marriages, Births, Re-locating, Job Changes, Graduations, Surgeries, Accidents, etc)

What stands out about growing up/ early development ?

Any physical abuse or domestic violence in the home you grew up in/ your child is growing up in?

Any sexual abuse history?

Family Mental Health History - any substance abuse, alcohol abuse or mental health issues in yourself (your child) or family members? Whom? Any hospitalizations or suicides?

Medications? Purpose? Prescribing Physician:

Any recent deaths of friends or families or pets?

Any re-locations or move?

Any current legal issues/ court?

Any current physical health issues?

Past experience with therapy or counseling?

What are your goals for therapy?

How long do you think you (your child) will be in therapy?

What are your (your child's) strengths?

Additional Notes - Please write any information you think is important for this therapist to know that was not asked about or mentioned above.

Date