

Kathy Garber, M.A, LMFT  
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## Child-Adolescent Intake

Please provide the following information about your child:

<b>Child's Full Name:</b>	<b>Nickname:</b>
<b>Birth Date:</b>	<b>Today's Date</b>
<b>Child's Address:</b>	<b>Phone:</b>
<b>Parent(s) names or primary guardian:</b>	<b>Parent(s) contact numbers:</b> Home: Cell: Work
<b>In case of emergency, who may I contact on your behalf?</b>	<b>Name:</b>
<b>Phone number:</b>	<b>Relationship:</b>

### Education History

<b>What school does your child attend:</b>	<b>Teacher's Name:</b>
<b>Current Grade:</b>	<b>Has your child ever repeated a grade? YES/ NO If so which one(s)_____</b>
<b>Favorite Subject:</b>	<b>Least Favorite Subject:</b>
<b>Does child receive special education service? YES /NO</b>	<b>Does child receive tutoring? YES/ NO</b>
<b>Is your child in a gifted/talented/honors program? YES/ NO</b>	<b>Does child like school? YES/ NO</b>
<b>Has you child experienced any of the following at school? (please circle all that apply)</b> Fighting, suspension, lack of friends, gang influence, learning disabilities, incomplete homework, dug/alcohol, poor attendance, behavior problems, detention ,poor grades	
<b>Has your child been the victim of bullying or bullied other children? YES/ NO.</b> If yes, please describe	
<b>Please, use the space to provide any other additional information regarding you child's education or developmental history that you find significant:</b>	

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**Medical History**

<b>Pediatrician's Name:</b>	<b>Phone:</b>
<b>Is child under the care of another medical specialist? YES/NO. If yes, type of specialist _____</b>	<b>Phone:</b>

**Please list any chronic illness, disabilities, medical conditions that your child has been diagnosed with:**

Illness/Disability	Dates

**List all medications that your child is currently taking:**

Medication	Dosage	Treating

**Therapy / Psychiatric Experience**

<b>Is your child <i>currently</i> seeing another therapist? YES / NO</b>			
If yes, who are you seeing?			
<b>Has your child ever been in therapy in the past YES/ NO</b>			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason
<b>Has your child ever had a psychiatric hospitalization? YES/ NO</b>			
If yes describe briefly and indicate dates and circumstances			
<b>Is your child under the care of a psychiatrist: YES/ NO</b>		<b>If yes, Psychiatrist name:</b>	
<b>Phone:</b>		<b>Address:</b>	

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**Other History**

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? YES/ NO  
If yes, please describe:

Has your child ever made statement of wanting to harm him/herself or seriously hurt someone else? YES/ NO  
Has he/she purposely hurt himself or another? YES/ NO  
If yes, to either question please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? YES/ NO.  
If yes, please explain:

Are there any behaviors that your child currently does too often, too much, or at the wrong times that gets him/her in trouble?  
YES/NO. If yes, please describe:

Are there any behaviors that your child fails to do as often as you would like or when you would like?

Please list positive strengths of your child: (What do you like about your child? What do others like about your child?)

How would you describe your child's self-esteem?

Briefly describe your reason(s) for seeking help at this time?

What goals do you wish to accomplish during the therapy process as a parent?



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Does anyone in the child's family been diagnosed with a chronic/mental illness? YES/ NO. If yes, please describe:

Is there anything else that you think would be important for me to know about your child, you, or your family?

Who referred you?