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TWEEN AND ADOLESCENT INTAKE FORM

This form is to be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Georgia law.

BACKGROUND INFORMATION

Child's Name _____

Date of Birth____/____/____ Age _____ Grade in School _____

Name of School _____

Child lives with (check one):
both biological parents _____ mother _____ father_____ other _____

If parents are divorced, describe custody arrangements (please also provide a copy of the court records showing custodianship):_____

_____

Child's Home Phone_____-_____-_____

Child'sAddress/City/St/Zip_____

_____

Emergency Contact Person (other than parent)

_____ Phone Number _____-_____-_____

Custodial parent's contact information: Name(s)_____

Home Phone _____Cell Phone _____

Work Phone_____E-mail_____
Which of these may we use to remind you of appointments (circle)? Home Work Cell
At which of these may we leave a message (circle)? Home Work Cell

Please list the other people residing in the home with your child:

Name	Relationship to Child	Age	Occupation/Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DESCRIBE THE ISSUE the child/adolescent is having:

_____

_____

_____

_____

Problem Areas: In the following list, please prioritize each item which identifies an area of concern to you regarding your child by numbering them. For example, the number 1 would be placed by the item concerning you the most today.

___ Anger
___ Anxiety
___ Behavior
___ Depression
___ Education
___ Family Problems
___ Fearfulness
___ Marital Issues
___ Problems with Social Relationships
___ Sexual Issues
___ Thoughts of Suicide
___ Trouble making decisions
___ Unhappy most of the time
___ Use of Alcohol
___ Use of Drugs
___ Worry
___ Other_____

Please describe any previous counseling/therapy for your child:

_____

_____

When did your child last consult with his/her primary care physician?

_____

Is your child currently taking any prescription medicines? If yes, please list by name and dosage:

_____

_____

Is there anything else which you believe might be important for your counselor to know at this time?_____

_____

Name of Parent(s)/Guardian (Printed)_____

Parent(s)/Guardian Signature(s) _____Date_____/_____/_____