DISCOVERY
COUNSELING CENTER

Child Intake Form

Personal Information for Child

Name: _____ **DOB:** _____ **Gender:** **M** **F**
(First) (MI) (Last)

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (___)_____ **Cell Phone:** (___)_____ **Email**: _____

School Name _____ **Grade** _____

Siblings: _____ **DOB:** _____ **At Home?** Yes No

_____ **DOB:** _____ **At Home?** Yes No

_____ **DOB:** _____ **At Home?** Yes No

_____ **DOB:** _____ **At Home?** Yes No

Parents Information

Father's Name: _____ **Mother's Name:** _____

Street Address: _____ **Street Address:** _____

City, State, Zip: _____ **City, State, Zip:** _____

Home Phone: _____ **Home Phone:** _____

Work Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Cell Phone:** _____

Email: _____ **Email:** _____

Marital Status: __ Married __ Separated __ Divorced __ Other _____

When necessary to contact you by phone, what number would you like the therapist to use? Circle all that apply**.**

Home Work Cell Other (if other please provide number) _____

May the therapist leave a message on your phone? Yes No

I give permission to have mail, if necessary, sent to my home. Yes No

In Case of Emergency

Notify: _____

Phone: _____ **Relationship:** _____

Cultural / Historical Background Information of Child

Language(s) spoken/written fluently: _____

Ethnic Group you most closely identify with: _____

Religious Affiliation(s): _____ **How often do you participate:** _____

Have you seen this type of therapist previously? Yes No

If yes, what type of therapy/counseling? (Circle all that apply) Individual Couples Family Group

Dates _____ **Therapist(s)** _____

Are you currently under the care of another therapist? Yes No **If so, whom?** _____

Are you currently having any of the following problems: (if so, specify)

Legal Problems _____ **Financial Problems** _____

Health Information

Any illnesses, injuries, impairments/limitations, allergies? Yes No **If so, explain:** _____

_____

Primary Care Physician: _____ **Date Last Physical Exam:** _____

Please list any prescriptions you are currently taking:

Drug: _____ **Dosage:** _____

Drug: _____ **Dosage:** _____

Drug: _____ **Dosage:** _____

Do you use over the counter medications? Yes No **If so, what and frequency?** _____

_____

Describe the quantity and frequency of your use of the following:

Alcohol _____

Drugs _____

Caffeine _____

Nicotine/Cigarettes _____

Is there a family history of:

Alcoholism _____

Substance Abuse _____

Mental or Emotional Illness _____

Prolonged Physical Illness _____

Current Life Issues / Problems

What issues or problems have brought you to Discovery Counseling Center? _____

_____

How were you referred to the Discovery Counseling Center?_____

Signed: _____ **Date**: _____

(Client or Parent/Guardian of a Minor)