Child Therapy Intake Form

Child's Name: _____ Date _____Race/Ethnicity:_____
Parent's name: _____

Reason (s) for seeking therapy:

_____
_____

Do you experience any of the following: _loneliness _Irritability _Tension/Stress _Anger _Sadness _Tiredness _Health Issues _Fears _Depression _Sleep Problems _Trust Issues _Self-Control _Thoughts of Suicide _Euphoria _Separation/Divorce _Weight _Worry/Anxiety _Concentration _Grief/Loss/Death _Panic Attacks _Memory Problems _Sexual Abuse _Lack of Confidence _Use of Drugs/Alcohol _Domestic Violence _Trouble making decisions

Have you been drinking alcoholic beverages in the past month? Yes__ No__ If Yes, How often?_____ How much?_____

Have you used drugs in the past month? (circle) Cocaine? Ice? Marijuana? Ecstasy? Opiates? Morphine? LSD? If Yes, How often?_____How long?_____

Have you ever received treatment for alcohol or drug abuse? Yes ___ No____

School and Grade Leve of your child: _____ Child's average grades:____ Any repeated classes/grade level:_____ Any behavioral issues at school? If so, please list:

_____