SAGE OWL THERAPY

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CHILD/ADOLESCENT INTAKE FORM

Today's Date _____

Please fill out this form and bring it to your first session.

CHILD'S NAME: _____ NICK NAME: _____

CHILD'S ADDRESS: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

CHILD'S D.O.B.: ___/___/____ AGE: _____ GENDER: □ M □ F

CHILD'S PRIMARY M.D._____ CLINIC: _____

WHO REFERRED YOU TO OUR OFFICE? _____ REASON FOR REFERRAL: _____

CHILD IS LIVING WITH: □ NATURAL PARENTS □ ADOPTIVE PARENTS □ ONE PARENT ALONE

□PARENT & STEP PARENT □ OTHER: _____

STATUS OF PARENTS: □ MARRIED □ SEPARATED □ DIVORCED □ WIDOWED □UNMARRIED

OTHER (SPECIFY):_____

WHO HAS LEGAL GUARDIANSHIP OF YOUR CHILD: _____?

PREFERED PARENT/GUARDIAN CONTACT NAME (S):_____

HOME PHONE: (_____) _____ CELL PHONE: (____) _____ WORK PHONE: (____) _____

MAY I LEAVE A MESSAGE? ☐ YES ☐ NO OK TO CONTACT THROUGH EMAIL? □ Y □ N
E-MAIL ADDRESS: _____
Please note Email is not considered a confidential medium of communication.

Occupation: _____ Workdays and hours: _____

Would you describe your work as stressful? □ Y □ N

OTHER PARENT/GUARDIAN NAME(S): _____

HOME PHONE: (_____) _____ CELL PHONE: (____) _____ WORK PHONE: (____) _____

OCCUPATION: _____ Workdays and hours_____

CHILD'S BROTHERS AND SISTERS

Name:	Sex:	Age:	How Related? Full/ Half Step/ Other	Relationship? Good/Fair/Discord

_____
_____
_____
_____
_____

Who in your family is your child closest to? _____

Most distant from? _____ In most conflict with? _____

Does your child sleep in his/her own bed? □Y □ N

CURRENT CONCERNS:

What happened and/ or why are you seeking counseling for your child at this time?

_____
_____
_____

How would you rate the intensity of the problems or concerns?
(1=NOT intense....10= VERY Intense)
1 2 3 4 5 6 7 8 9 10

How long have these problems occurred?

_____

How has the family attempted to deal with these concerns? List the 3 most common methods:

1._____
2._____
3. _____

What changes would you like to see in your child? Please list all you can think of.

_____

Has your child ever seen a therapist/psychologist/counselor before? Please explain:

_____
_____

OTHER INFORMATION:

What are your child's hobbies and interests?

_____
_____
_____

What are your child's strengths and talents?

_____
_____
_____
_____

Does your family have specific spiritual beliefs?

_____

Religious background: _____

What cultural affiliation does your child have? _____

In what joint activities do you engage as a family?

Activity Frequency (rarely, occasionally, often)

1. _____
2. _____
3. _____

LEGAL INFORMATION

If the parents are separated or divorced, what is the current child custody/visitation arrangement?

_____
_____

Is your child currently the subject of a custody case? □ Yes □ No

Does your child have any legal offenses on record or pending in the courts? ☐Yes □ No

If adopted, does child know of adoption? □Yes □ No

If not, please explain:

_____

Other Helpful Information:

_____
_____
_____

FAMILY HISTORY:

Who are your child's significant others NOT living with your child?

Names Ages Relationship to child

_____
_____
_____
_____

Please describe any past counseling that either your child or any family member has had.

_____

_____

_____

_____

Does anyone in the child's family use currently (or in the past) any type of drug or alcohol? If yes, please describe:

_____

_____

EDUCATION:

What school does your child attend? _____

Address: _____

Phone: _____ Teachers Name: _____Current Grade: ____

What does your child's teacher say about him/her?

_____

_____

_____

_____

Has your child ever repeated a grade? If so which one(s)

_____

Has your child ever received special education services?

_____

_____

Has your child experienced any of the following problems at School?

Fighting lack of friends drug/alcohol detention

Suspension learning disabilities poor attendance poor grades

Gang influence incomplete homework behavior problems

MEDICAL HISTORY:

What is the name of your child's medical doctor? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____

Please list any medications your child takes on a regular basis, reason for medication, and how long:

_____

_____
_____
_____

Please list current health concerns: _____

_____

Has the child ever been admitted to a psychiatric hospital? Yes No

If yes, please explain: _____
_____Age ____
Admitted: How long: _____
Reason / Diagnosis: _____
Recommendations/Medications:
_____
_____

Has the child ever seen a medical specialist? Yes No
If yes, please explain: Age/ How long/ Reason/diagnosis/ Recommendations/Medications:
_____
_____
_____

OTHER HISTORY:

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so please describe:
_____
_____
_____
_____

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else?
_____
_____
_____
_____

Has he/she ever purposely hurt himself or another?
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)? If yes, please explain:
_____
_____
_____
_____

Finally, what are some of the things that are currently stressful to your child and his/her family?

_____
_____

What changes would you like to see in you and your family?

_____
_____

How much must they change for you to be satisfied?
_____

Parent Signature: _____
Date
Therapist Signature: _____
Date

Please check all times you are available for therapy

Tuesday: 1:00-5:30 _____
Wednesday: 1:00-5:30 _____
Thursday: 1:00-5:30 _____
Friday: 8:00-1:00 _____ 1:00-6:00_____
Saturday: 10:00-3:00 _____

Comments on time frame: _____