Health & Wellness Counseling Center

Child Intake Form

Date of initial appointment: _____

Client's name:_____
Parent's name(s):_____
Address:_____
DOB:_____
Email address (if any):_____
Preferred phone(s) #:_____ _____
Name of person(s) to be contacted in case of an emergency/Phone #:
_____

Please describe your primary reason for seeking assistance:

_____
_____
_____
_____
_____
_____

Please list current medications with current dosages:

_____
_____
_____
_____
_____

Please list any relevant counseling history and/or inpatient treatment history:

_____
_____
_____
_____
_____
_____

Is your child experiencing any of the following?

Depressed mood	Yes / No
Mood swings	Yes / No
Poor self-esteem	Yes / No
Rapid speech	Yes / No
Anxiety/nervousness	Yes / No
Panic attacks	Yes / No
Phobias	Yes / No
Sleep disturbances	Yes / No
Hallucinations	Yes / No
Alcohol/substance abuse	Yes / No
Problematic eating/eating disorder	Yes / No
Repetitive thoughts/behaviors (e.g. obsessions)	Yes / No
Home stressors	Yes / No
Suicidal thoughts	Yes / No
Self-harm/abusive behaviors	Yes / No

EDUCATIONAL HISTORY

Current school:_____

Current grade:_____

Current guidance counselor:_____

Please list any concerns pertaining to your child's education:

_____

_____

_____

Please indicate if your child is currently receiving any educational services such as an IEP or 504 plan: _____

PERSONS IN HOUSEHOLD

NAME	AGE	RELATIONSHIP	OCCUPATION
1.			
2.			
3.			
4.			
5.			

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (immediate family members or relatives) experienced difficulties with the following? (Circle any that apply and list family member, e.g. sibling parent, uncle, etc.)

Difficulty	Yes / No	Family member
Depression	Yes / No	
Bipolar disorder	Yes / No	
Anxiety disorder	Yes / No	
Panic attacks	Yes / No	
Schizophrenia	Yes / No	
Alcohol/substance abuse	Yes / No	
Eating disorders	Yes / No	
Learning disabilities	Yes / No	
Trauma history	Yes / No	
Suicide attempts	Yes / No	
Chronic illness	Yes / No	

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OFFICE POLICY ON LATE CANCEL/NO SHOW FEE

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

Therefore, The Health & Wellness Counseling Center reserves the right to charge a $40.00 fee for missed appointments ("no shows") and appointments which, absent a compelling reason, are not cancelled within a 24-hour advance notice.

Please sign and date below stating that you are aware of this policy that is in effect.

Patient Name (Print):_____

Patient's D.O.B:_____

Parent's signature:_____

Date:_____