lifeWORKS
COUNSELING CENTER

CHILD/ADOLESCENT INTAKE FORM

YOUTH INFORMATION

Name____ Gender M or F

Birthdate ___/___/___ Age_______

School ______________________________________

Teacher ___________________________ Grade______

Employment____

Phone ____/____/____

Personal Phone____/____/____

Address_______________________________

City/State________________

Reason for coming to counseling today
____
____
____

RESPONSIBLE PARTY INFORMATION

Name____

Relationship to the youth ____

Occupation ____

Place of employment____

Phone ____/____/______

Do we have permission to call you at work if necessary? ____ yes _____ no

Cell Phone ____/____/_______

Spouse's name __________________________________

Relationship to the youth ___________________________

Occupation ______________________________________

Place of employment ____________________ Phone _____________

Biological Mother____

Occupation ______________________________________

Place of employment ____________________ Phone ____/____/_____

Biological Father ____

Occupation _______________________________________

Place of employment ____________________ Phone ____/____/_____

Step Mother ____

Occupation _______________________________________

Place of employment ____________________ Phone ____/____/_____

Step Father ____

Occupation _______________________________________

Place of employment ____________________ Phone ____/____/_____

Marital Status of the biological parent(s)
____ married ____ separated ____divorced ____ widowed

If divorced, please answer the following questions:

Year of divorce________

Which parent makes the decision for non-emergency medical care for this youth?
___Mother ____Father ____Joint

What are the visitation arrangements for the other parent?
____
____

Has either parent remarried? Mother ___ yes ___ no
If yes, year of remarriage______________________

Father ___yes ___ no
If yes, year of remarriage_____________________

Please list any biological siblings this child may have in order of their births.

____________________________________ Age_______
Are they an active part of his/her life? ___yes ___no

____________________________________ Age_______
Are they an active part of his/her life? ___yes ___no

____________________________________ Age_______
Are they an active part of his/her life? ___yes ___no

Please list any step siblings this child may have in order of their births.

____________________________________ Age_______
Are they an active part of his/her life? ___yes ___no

____________________________________ Age_______
Are they an active part of his/her life? ___yes ___no

____________________________________ Age_______
Are they an active part of his/her life? ___yes ___no

MEDICAL/COUNSELING HISTORY

Name of medical doctor ____

Date of last physical exam _____________

For what medical problems is the child being treated currently?
____

Please list all medications currently being taken and the reason they have been prescribed.

If you or your child has seen a counselor before, please give the counselor's name and the reason for pursuing counseling at that time.

Counselor Reason

What do you hope to achieve through this counseling experience?

Was this child referred for counseling? _________
If so, by whom? ____

Does your family ascribe to any religious affiliation? ________
If so, what type? ____

Note: Please take younger children to the restroom before the session begins and do not leave the building during the time your child is with the counselor.

The session length will be determined by the counselor, which may or may not include time allowed for follow-up conversation with the parent.

Guardian's Signature____

Date ____/____/_____