Intake Questionnaire for Child Psychotherapy

** indicates a required field*

This form is to be completed by the Parent/Guardian of the client prior to the initial visit.

*** Your child's name:**

*** Your child's age:**

*** Your child's date of birth:**

*** Your child's gender:**

Medical Information

*** Who lives in the household with your child?**

Physician's address

Name of physician

Physician's phone number

*** List any medications your child is currently taking, including the dosage, frequency, and any side effects experienced. If none, put "n/a."**

*** Does your child have any current health condition?**

- ○ Yes
- ○ No

Educational Information

*** Does your child attend school?**

- ○ Yes
- ○ No

Name of school

*** Teacher/grade**

School address

School phone number

Classroom type

*** Do you have any concerns about your child's school?**

- ○ Yes
- ○ No

*** Do you have concerns about your child's behaviors at school?**

- ○ Yes
- ○ No

Treatment History

*** Has your child received any psychological services?**

- ○ Yes
- ○ No

*** What concerns do you have about your child?**

*** Does your child currently have any diagnoses?**

○ Yes

○ No

Referred by

Child’s Current Behaviors and Expected Outcomes

*** Please state the expectations/goals that you have for your child's therapy.**

Please list any other information that may be helpful while assessing and/or conducting therapy with your child.