BEACON **FAMILY** CONSULTING
PLLC

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CONFIDENTIAL CLIENT INTAKE FORM (CHILD)

Today's Date: ____ / ____ / ____

CLIENT INFORMATION:

Client Name: ____ Date of Birth: ____ / ____ / ____

Grade/School: ____

Address: ____

City:____________________________________ State: _______________ Zip: _______________

Phone (Home) _________________ (Cell) __________________ (Work) ______________________

PARENT INFORMATION:

Mother's Name: ____

Phone (Home) ________________ (Cell) __________________ (Work) ______________________

Is it okay to leave a message on your home phone? ☐ Yes ☐ No

Is it okay to leave a message on your cell phone? ☐ Yes ☐ No

Email Address: ____

Is it okay to communicate via email? ☐ Yes ☐ No

Occupation of Mother: ____

Father's Name: ____

Phone (Home) _______________ (Cell) _______________ (Work) ___________________

Is it okay to leave a message on your home phone? ☐ Yes ☐ No

Is it okay to leave a message on your cell phone? ☐ Yes ☐ No

Email Address: ____

Is it okay to communicate via email? ☐ Yes ☐ No

Occupation of Father: ____

Continued

Relationship of parents: ☐ Married ☐ Separated ☐ Divorced ☐ Not married

Who does the child live with? ______________________________

Who has child custody (if separated or divorced)? ______________________________

Siblings (Names and ages): ______________________________

Others living in Client's home: ______________________________

PARENT INFORMATION:

Name: ______________________________ Phone: ______________

Name: ______________________________ Phone: ______________

What brings you or your child to seek therapy now and what do you hope to gain?

Describe your child's strengths:

What are your strengths as an individual/parent(s)/ family?

Continued

What helps your child make it through challenging times? (sports, friends, animals, family, etc)

How would you describe your child's temperament/ personality?

What do you and your family like to do for 'family time'?

What does your child enjoy doing with his/her free time?

Please briefly describe the social/peer support of your child.

Continued

Are you and/or your family affiliated with any spiritual/ religious based groups? ☐ Yes ☐ No

Does your child appear to find comfort in his/her spiritual/religious beliefs? ☐ Yes ☐ No

When you leave our first session, what do you hope to have gained?

HISTORY:

Developmental Milestones (within normal range?) ☐ Yes ☐ No (if no, please explain)

Is there any history of mental health concerns in your family? ☐ Yes ☐ No
(If yes, please describe)

Substance abuse? ☐ Yes ☐ No (who?) ______________________________

Treatment? ☐ Yes ☐ No

Continued

Educational difficulties? ☐ Yes ☐ No
(If yes, please explain)

Sleep difficulties? ☐ Yes ☐ No
(If yes, please explain)

Speech/Language concerns? ☐ Yes ☐ No

Physical health conditions? ☐ Yes ☐ No
(If yes, please explain briefly)

Is your child currently taking any medications? ☐ Yes ☐ No
(If yes, please explain)

Continued

Please check any current or past problems that your child has experienced:

- ☐ Depression
- ☐ Past trauma
- ☐ Health problems
- ☐ Attention/focusing
- ☐ Sleep problems
- ☐ Anxiety
- ☐ Domestic violence
- ☐ Education concerns
- ☐ Death/major loss
- ☐ Anxiety/fear
- ☐ Parent/child conflict
- ☐ Suicidal thoughts/action
- ☐ Compulsive behavior
- ☐ Self esteem
- ☐ Relational problems
- ☐ Separation/divorce
- ☐ Issues with peers/ bullying
- ☐ Drug alcohol
- ☐ Lack of energy
- ☐ Repetitive behaviors
- ☐ Visual/auditory hallucinations
- ☐ Abuse
- ☐ Disordered eating
- ☐ Substance use

Please note any additional family history you feel is relevant to working with your child:

Previous therapy? (When? Was it beneficial? What worked, what did not?)

Parent signature

Parent signature

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