IP.COUNSELING
Put Your Life Into Balance

Client Intake Form: Child/Teen

Date: _____

Please fill out the following information.

Name of Child :_____ Age:_____
SSN of child:
_____ Birthdate:_____

Gender/Gender Identity: _____

Address:_____ City: _____

_____ Zip: _____ Email: _____

Adult cell: _____ May we leave a message via phone?: Yes ☐ No ☐

Adult home: _____ May we email parent/guardian ?: Yes ☐ No ☐

Are you the Parent and/or Legal Guardian of child? Yes ☐ No ☐

Emergency Contact Information:

Name:_____ Relationship: _____

Phone: _____ SSN of parent: _____

Is child currently in therapy or counseling? Yes ☐ No ☐

Counselor Name: _____ Agency Name: _____

Reason: _____

_____

_____

Phone:_____ Permission to Contact: Yes ☐ No ☐

Therapy/Counseling History:

Has child ever been in counseling before? Yes ☐ No ☐

When:_____ Agency Name: _____

Reason: _____

_____

_____

Please state in your own words why the child is being brought for treatment:

_____

_____

_____

Medical History

Physician Name: _____ Phone Number: _____

List any health issues: _____

_____

_____

_____

_____

Medication Name	Dosage (mg/daily)	Dates Taken	Purpose

Please list any developmental difficulties:

_____

_____

_____

_____

What changes do you wish to see as a result of the child's treatment?:

_____

_____

_____

_____

_____

_____

Known or suspected **trauma, abuse** (physical, sexual, emotional, verbal, mental), **neglect or abandonment** of the child:

_____

_____

_____

_____

Is the child currently safe?_____

Child Problem Areas/Areas of Concern

Symptoms		Explanation
➢	Sadness	
➢	Anger/irritability	
➢	Guilt	
➢	Fear	
➢	Shame	
➢	Panic/anxiety	
➢	Loneliness	
➢	Hopelessness	
➢	Emptiness	
➢	Numbness	
➢	Worthlessness	
➢	Depression	
➢	Regression	
➢	Withdrawn/ isolation	
➢	Clinging behavior	
➢	Language issues	
➢	Violence/ Rage	
➢	Disruptive behavior	
➢	Substance use	
➢	Phobias	
➢	Hyperactivity	
➢	Sleep changes	
➢	Suicide attempts/ thoughts/ plans	
➢	Seizures	
➢	Self-harm	
➢	Temper/ outburst	
➢	Separation anxiety	
➢	Memory issues	
➢	Hearing voices	
➢	Seeing things	
➢	Body image struggles	
➢	Lack of concentration	
➢	Change in school performance	
➢	Personality change	
➢	Medical trauma	
➢	Changes in relationships with family or friends	
➢	Recent loss or unresolved grief	
➢	Wetting/ soiling	
➢	Eating/sleeping problems	
➢	Other:	

Family Structure

Family Members at Home

Name	Relationship	Age

Family Members Not at Home

Name	Relationship	Age

Family History of Mental Illness and/or traumatic events (known or suspected):

Any additional information regarding child's current state and functioning, continue on back:

Counselor Signature	**Date**
Client or Custodial Parent/Legal Guardian Signature **(By signing, I confirm that all legal custodial parents are aware child is receiving treatment)**	**Date**