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Transitions Counseling, LLC

# Child Intake Information

Child'sFullName:_____DOB:_____Age:_____
_
Child's Primary Address (If
Different):_____
_____
_____
Who has custody of this child?
_____
Does he/she reside with you?
_____

Where does your child attend school?_____
Grade:_____
Are there any special accommodations for your child at school? (IEP, 504, etc)
_____
_____
Is your child currently in therapy with a therapist? _____yes _____ no
If yes, please write their name, how long they have been seeing them,
and for what reason they have been in therapy
_____
_____
Has your child terminated therapy with them? _____ yes _____ no
If yes, did they have a termination session with them? _____yes _____no
Has your child had any other previous counseling/therapy? If so, when, with whom and
reason_____
_
_____
Were these experiences positive?
_____
If no, please explain_____
Has your child ever been hospitalized for a psychiatric reason? Please
give dates, hospital, doctor and
diagnosis_____
_____

Has your child ever attempted suicide or expressed suicidal thoughts? If so, when_____

_____

Has your child ever received psychological assessment/testing? If yes, please give dates, type of testing and briefly describe the results_____

_____

_____

_____

Is your child currently being treated by a Psychiatrist? If yes, who are they seeing and how long have they been under their care?

_____

What are the medications/dosage are they being prescribed?

_____

_____

Who is your child's medical doctor?

_____

May I contact them regarding treatment or referral if necessary? _____ yes _____no