



Trinity Christian Counseling  
Suites 300 and 309  
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## CHILD INTAKE FORM

Date \_\_\_\_\_

### Child's Information

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Grade level \_\_\_\_\_

### Mother's Information

Mother's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Okay to leave detailed message  Y  N

Mothers marital status  Married  Divorced  Engaged  Widowed  Separated

Mother's religious affiliation \_\_\_\_\_

Mother's email \_\_\_\_\_

Mother's employer \_\_\_\_\_

### Father's Information

Father's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell \_\_\_\_\_

Okay to leave detailed message  Y  N

Father's marital status  Married  Divorced  Engaged  Widowed  Separated

Father's religious affiliation \_\_\_\_\_

Father's email \_\_\_\_\_

Father's employer \_\_\_\_\_

**Emergency contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

**Family Information**

Who currently resides in the home? Please include any half or step brothers and sisters, grandparents or any others.

Name	Age	Relationship
_____		
_____		
_____		
_____		
_____		

Name of child's PCP \_\_\_\_\_ Phone number \_\_\_\_\_

Date of last well child exam \_\_\_\_\_ Does your child exercise regularly?  Yes  No

What type of exercise? \_\_\_\_\_

Does your child have any chronic medical conditions?  
\_\_\_\_\_  
\_\_\_\_\_

List any medications including over the counter and supplements.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child smoke?  Cigarettes  Marijuana  Chew Tobacco  Vape

How much per day? \_\_\_\_\_

Does your child drink alcohol  Y  N How much \_\_\_\_\_ How often \_\_\_\_\_

Has your child had any previous trauma? (physical, sexual, emotional)  Y  N

Please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How does your child handle stress?  
\_\_\_\_\_  
\_\_\_\_\_

Please check any of the following your child has gone through in the past 12 months and briefly explain

Death of a parent  Y  N \_\_\_\_\_

Divorce of parents  Y  N \_\_\_\_\_

Separation of parents  Y  N \_\_\_\_\_

Remarriage of a parent  Y  N \_\_\_\_\_

Death of a family member  Y  N \_\_\_\_\_

Personal injury or illness  Y  N \_\_\_\_\_

Sexual abuse  Y  N \_\_\_\_\_

Addition to family  Y  N \_\_\_\_\_

Sibling leaving home  Y  N \_\_\_\_\_

Financial difficulties for parents  Y  N \_\_\_\_\_

Loss of home  Y  N \_\_\_\_\_

Outstanding personal achievement  Y  N \_\_\_\_\_

Parent change in job or work hours  Y  N \_\_\_\_\_

Imprisonment  Y  N \_\_\_\_\_

Minor violation of the law  Y  N \_\_\_\_\_

Change in residence or school  Y  N \_\_\_\_\_

Change in social activities or recreational activities  Y  N \_\_\_\_\_

Change in eating or sleeping  Y  N \_\_\_\_\_

Revision of personal habits  Y  N \_\_\_\_\_

Please list any other changes you may have noticed that may help your therapist:

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**Insurance Information**

Insurance carrier \_\_\_\_\_

Subscribers name \_\_\_\_\_ Date of birth \_\_\_\_\_

Contract number \_\_\_\_\_ Group number \_\_\_\_\_

Signature \_\_\_\_\_

I \_\_\_\_\_ hereby understand that if my insurance will not cover my sessions with any provider from Trinity Christian Counseling that I will be responsible for any payment in full at time of session.

I \_\_\_\_\_ agree that I have answered the above statements to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Thank you,

**Trinity Christian Counseling,**

**David Brown DCE, LPC, NCC**

**Kathleen von Kampen DCE, LLMFT**

**Kristin Hardy DCE, LPC, NCC**

**Danial Burke MA, LLP**