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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?

_____

_____

_____

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

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:

_____

_____

_____

Insurance Information

Insurance carrier _____

Subscribers name_____ Date of birth_____

Contract number_____ Group number_____

Signature_____

I _____herby 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

Kristin Hardy DCE, LPC, NCC

Zhela Bennett, LLPC

Danial Burke MA, LLP