Patient Intake Form - For Child (MH)

Name:_____ Date:_____

In order to provide you with the service you expect, we need to begin with information from you. Please complete the following:

Briefly describe your reason for obtaining service for your child:_____

_____

_____

_____

Have you received treatment for this issue or problem in the past year? Yes _____ No_____

Please provide dates of treatment and name of provider who has treated your child:

_____

_____

What is the name of your child's primary care physician?

Physician: _____ Address:_____

Telephone:_____ Date of Last Examination: _____

Please list any medications your child is currently taking:_____

_____

_____

_____

Please list any health problems for which your child has been treated:_____

_____

_____

_____

Please list all family members residing in the home:

NAME AGE HIGHEST GRADE COMPLETED

_____

_____

_____

_____

_____

_____

_____

Child's School:_____Grade:_____

Has your child been placed in Special Education Classes? Yes_____ No _____

Please describe below any special concerns, questions, or information you believe will be helpful in developing your child's treatment program:

_____

_____

_____

_____

Who suggested you contact us? Self _____ Physician _____ Friend _____ Other_____

If a Physician referred, please list name: _____

Address/Telephone: _____

Please complete the following page as honestly as possible. Thank you.