-Child Counseling Intake ~ Sonja Wanhala, LMFT-

Client name: ____ Birthdate: ____________________________

Address: _____________________________________City, State, Zip: ______________________________

Home phone: (____) ___________________Parent cell phone: (____) ____________________________

Parent E-mail:____

How would you like to be contacted: ( ) Home phone ( ) Cell phone ( ) E-mail ( )Text Message

Pediatrician Name:______________________________PhoneNumber: (____)_______________________

Would you like a reminder the day before your appointment: ( ) No ( )Yes

Please describe your reasons for seeking therapy at this time:_______________________________________

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Family Information:

Family Members & Roommates Living in the Home

Name	Gender	Age	Relationship	School	Occupation

Parent Name(s):____

Relationship of Parents: ( ) Married ( ) Separated ( ) Divorced ( ) Never Married

Custody Arrangements: Legal:____________________Physical:__________________________________

Siblings or Immediate Family Members Living Outside of the Home:

____

Language(s) spoken at home:______________Language(s) at school:________________________________

Have there been any moves? yes or no If so, when:_____________________where:________________

Pets:____

Academic History:

Name of school attending: ______________________________________Grade: ________________

Skipped a Grade? yes or no When:________ Retained: yes or no When:______________________

Other Schools Attended & When:____

Is your child in: ( )GATE ( ) RSP ( ) Speech Therapy ( ) Occupational Therapy ( ) Mentor Me

Does your child have an IEP: ( ) Yes ( ) No

Academic Strengths &
Interests:____

Academic Areas of Concern:____

Peer Relationships:____

Health History:

What was the pregnancy and birth like? ____

____

Did your child reach developmental milestones within normal limits? (crawling, walking, talking):

( ) Yes ( ) No Please Describe:____

History of any health issues or conditions: ____

Medications:____

Nutritional Habits:____

Physical Activity:____

Sleep:____

How many hours of screen time (tablet, IPad, smart phone, laptop or computer) per week:______________

Mental Health History:

Has your child received prior therapy or counseling? Yes or No If yes, when?______________________

Counselor Name(s):____

Has your child been under the care of a psychiatrist? Yes or No If yes, when:______________________

Psychiatrist's Name:____

Is there a history of mental illness in the family? ____

Has your child ever had thoughts of hurting themselves or others: ( ) Yes ( ) No

If yes, please explain:____