TheTherapyDr.

850 E. Higgins Rd Suite 119 Schaumburg IL 60173 Telephone:847-242-1511

Child and Adolescent Therapy Intake

Today's Date_____

Child/Adolescent Name: _____ Birthdate:_____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Ph#: _____ Cell Ph#:_____

Email address if you would like to be contacted for administration purposes:

_____

INFORMATION ABOUT CHILD'S MOTHER

Mother's Name _____ Age _____

Employer _____ Occupation _____Hrs/wk

cell phone _____

INFORMATION ABOUT CHILD'S FATHER

Father's Name _____ Age _____

Employer _____ Occupation _____ Hrs/wk

Cell phone _____

GENERAL INFORMATION ON CHILD/ADOLESCENT:

Child's Physician: _____ Phone#_____

Has your child ever been tested by a psychologist? Yes/No If yes, please give date and reason:

_____

Has your child ever been placed in a psychiatric hospital? Yes/No If yes, please give date and reason:

_____

Is your child currently in therapy/counseling? Yes/No

Has your child received therapy/counseling in the past? Yes/No

If yes, to either of the above, please fill out the following information: Reason_____

Name of therapist/counselor: _____Date/Length of treatment_____
Has your child previously taken any medications for emotional/behavioral problems? Yes/No
If yes, please describe:_____

FAMILY DYNAMICS:

Additional people currently living in the home:

Name:_____Age:_____ Relationship to the child:_____

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Name:_____Age:_____ Relationship to the child:_____

Name:_____Age:_____ Relationship to the child:_____

EDUCATION INFORMATION:

Is your child currently enrolled in school/daycare? Yes/No

How many schools daycares has your child attended in the last year? _____

Name of school/daycare: _____ Grade: _____ Name of Teacher: _____

Describe your child's academic performance over the past school year: GOOD FAIR POOR

If POOR, please explain: _____

Is your child's behavior a problem in his/her school? Yes/No If yes, please

describe:_____

EDUCATION INFORMATION

Does your child attend Other School_____

Name of Other School_____

HEALTH INFORMATION ON CHILD/ADOLESCENT:

Does your child have any chronic illnesses, genetic illnesses, allergies or handicaps? Yes/No

If yes, please describe:_____

Is your child currently being treated for any illnesses? Yes/No If yes, what type_____

Is your child taking any medication at this time? Yes/No If yes, what kind_____

BEHAVIORAL INFORMATION:

Have there been any significant events in your child's life in the past 12 months? Yes/No

If YES, please

Explain:_____

Please let us know whom we can thank for referral

_____