Whittaker Psychological Services

Child Intake Information Form

Date: _____

Client name: _____ Date of Birth: ___ /___ /___ Age: ___

Name of Parent/Guardian completing form: _____

Address: _____

Please indicate your preferred means of contact:

☐ Home Phone: _____ May I leave a message? ☐Yes ☐No

☐ Cell Phone: _____ May I leave a message? ☐Yes ☐No

☐ Alternate Number: _____ May I leave a message? ☐Yes ☐No

☐ Email Address: _____

Racial/Ethnic Background: _____

Emergency Contact

Name: _____ Phone: _____ Relationship: _____
May I leave a message? Yes/No

Please describe your reason for seeking therapy for your child at this time:

_____

_____

_____

_____

Pediatrician Contact

Name Address Telephone Contact

_____ _____ _____

School Name: _____

Address: _____

Grade: _____

CSE/CPSE Classification (if any): _____

Services received at school (if any): _____

_____

Family

Parents' marital status:

☐ Married ☐ Divorced ☐ Separated ☐ Never married ☐ Living together

If divorced, please indicate custody situation: _____

Please list all household member:

Name	Age	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe the child's relationship with other family members where applicable:
Mother: _____
Father: _____
Siblings: _____
Other: _____

Please describe previous psychological services your child has received (if any):

Therapist	Duration	Reason	Outcome
_____	_____	_____	_____
_____	_____	_____	_____

Has your child ever taken medications for a mental health problem? ☐ Yes ☐No
If yes, please indicate:

Duration	Reason	Outcome
_____	_____	_____
_____	_____	_____

Is your child currently taking any medication? ☐ Yes ☐No If Yes, please indicate:

Medication Name	Reason	How long on medication
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever been hospitalized for a mental health problem? ☐ Yes ☐ No If Yes, please describe:

_____

Medical History

Does your child currently have a physical illness or medical problem? □ Yes □ No If Yes, please describe: _____

Has your child ever been hospitalized for a severe injury? □ Yes □ No If Yes, please describe: _____

Abuse History

Has your child ever been abused? □ Yes □ No If Yes, please indicate:

□ sexual □ physical □ verbal □ emotional □ neglect

Age	By whom	How long did the abuse occur	Effect on child
____	_____	_____	_____
____	_____	_____	_____

What significant life changes or stressful events is your family/your child currently experiencing or have recently experienced? _____

_____

_____

Please indicate your goals for therapy: _____

_____

_____

_____

Additional information

Please indicate if there is anything else that you would like to share. _____

_____

_____

Referral source: How did you find out about Whittaker Psychological Services?

_____