Child/Teen Client Intake Form

Child Name: ________________________________ Date of Birth: __________________

Parent(s)/Guardian(s): ____

Custody Arrangements/Living Situation: ____

Second Address/Phone: ____

School: __________________________ Grade: _________ Teacher: ________________

People in Household:

Name	Relationship	Male/Female	Age

1.	Do you like your school?	Y	N
	If no, what don't you like?		
2.	Do you ever get into trouble at school?	Y	N
	Is yes, how often and for what?		
3.	Do you have as many friends as you would like?	Y	N
4.	Is there any grown-up in your life you trust enough to talk openly with?	Y	N
	Who?		
5.	Have you ever seen a counselor before?	Y	N
	If yes, when, where, and why?		

6.	What are your favorite things to do?		
7.	Do you have any worries about your weight or the way you look?	Y	N
8.	Do any of your friends or family members use drugs or alcohol?	Y	N
	Or have they used them in the past?	Y	N
9.	Do you currently use drugs or alcohol?	Y	N
	Have you in the past?	Y	N
10.	Have you ever had any thoughts about hurting yourself or others?	Y	N
11.	Do you ever have bad dreams or problems sleeping?	Y	N

What else should I know about you? ____

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