Humanistic Counseling Center

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Child and Adolescent Intake Form
And Permission to Treat

Date: _____

Therapist:_____

Child/Adolescent's Last Name_____First_____Age_____

Birth Date_____Gender M F Other Religion_____

Grade_____School_____

Who lives in your household (names and ages)_____

_____

Date of most recent physical exam_____Eye Exam_____Hearing Exam_____

Does Client have any relevant medical condition?_____

_____

Allergies?_____

Prior Therapy or Hospitalizations:

Dates	Name of facility, doctor, or therapist	Condition

Current medications, dosage, and prescribing doctor(s)_____

_____

Describe any mental health conditions and/or alcohol, drugs, or tobacco use in the family (who/what)

_____

_____

Father's Name_____Age_____

Address _____

(if different)

City_____Zip_____

Phone:(H)_____(C)_____

Mother's Name_____Age_____

Address_____

(if different)

City_____Zip_____

Phone:(H)_____(C)_____

I am the ____the parent or_____legal guardian of_____and I authorize outpatient psychotherapy for _____. We need a copy of any legal documents related to the ability to allow services.

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