Humanistic Counseling Center
PO Box 24242
Cleveland, OH 44124
P: 216-839-2273
F: 216-896-0735

Child and Adolescent Intake Form and Permission to Treat

Date: ____________________________
Therapist:____________________________

Child/Adolescent's Last Name_______________First______________Birth Date__________________

Gender Identity/Administrative Identity ___________/_________ Religion_______________________

Grade________________ School____

Who lives in your household (names and ages)____

Does Client have any relevant medical conditions?____

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 (I.e. who/what)

____

Father's Name________________________Age_________ Mother's Name_____________Age___

Address ______________________________________ Address_________________________________

City____________________________Zip_________ City______________________________Zip_________

Phone:(H)_______________(C)________________ Phone:(H)__________________(C)_______________

I am the _____the parent or______legal guardian of____________________________and I authorize outpatient psychotherapy services.

Parent/Guardian Signature: ____.

We need a copy of any legal documents related to the ability to allow services.