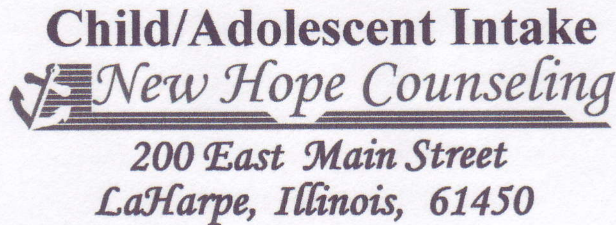
Child/Adolescent Intake



200 East Main Street
LaHarpe, Illinois, 61450

PERSONAL INFORMATION

Child/Adolescent's Name ______________________ **Date of Birth** ______________

Address ______________________ **Phone #** ______________

FAMILY INFORMATION

Mother's name ______________________ **Age** ____ **Marital Status** ______________

Education ____________ **Place of employment** ____________ **Phone #** ____________

Father's name ______________________ **Age** ____ **Marital Status** ______________

Education ____________ **Place of employment** ____________ **Phone #** ____________

Who has legal custody? Mom _____ **Dad** _____ **Joint** _____ **Other (specify)** ______________

Siblings – Names and ages ______________________________

Who lives in home with child? ______________________________

INSURANCE *(The office will need a copy of both sides of your insurance card)*

Name of insurance provider ______________________ Phone # ______________

Insured Name ______________________ DOB ____________ ID # ______________

Policy # ______________________ Group # ____________ SSN # ______________

FAMILY HISTORY (Mother/Father)

Physical or Psychiatric Illness ______________________________

Learning Problems ______________________________

CHILD'S HEALTH HISTORY

Physician or Pediatrician ______________________ Phone # ______________

Illnesses other than usual childhood illnesses? If so, what and when? ______________________

Any significant losses the child has experienced ______________________

Any hospitalizations or surgeries ______________________

Current medications ______________________

Any previous counseling? With whom? ______________________ When? ______________

Any suicidal ideation? ______________ Any sleep or appetite problems? ______________

Any infectious deseases? Yes _____ No _____ If yes, explain ______________

Any history of physical or sexual abuse? Yes _____ No _____ If yes, explain ______________

SCHOOL INFORMATION

Name of school ______________________________

Any problems at school? ______________________________

REASON FOR SEEKING HELP ______________________________

____

I give my permission for the minor named above to participate in the counseling services of New Hope Counseling

Parents/Guardians Signature ______________________ **Date** ______________