Anne Drake, LCSW
COUNSELING AND PLAY THERAPY

Welcome ! Please answer each question with as much information as possible before your first appointment. All information is strictly confidential and beneficial in providing the best possible services. Feel free to ask for assistance or clarification if needed, and include any additional information you feel may be helpful in understanding your child.

Date of Intake: _____

Client Registration and Intake Information

Child's Name: _____

Date of Birth: _____ Age at time of Intake: _____

Contact Information

Completed By: _____ Relationship to Child: _____

Cell Phone: _____ Email address: _____

Home Address: _____

City: _____ Zip: _____

Insurance Information

Insurance Provider: _____

Address/phone: _____ City: _____ Zip: _____

Group number: _____ Policy Number: _____

Subscriber Name: _____ Subscriber Birthdate: _____

Effective Date: _____

*Please provide a copy of the front and back of your insurance card.

Intake Information

Child's Primary Language: English Spanish Sign Language Other_____

Language spoken at home (parent's language): _____

What language do you use to communicate with your child? _____

Has your child previously received counseling services? Yes No

* If yes, please complete *Release of Information* page.

Name of Counselor: _____

Current Diagnosis (if any): _____

Age/Date of Diagnosis: _____

Child's Caregiver (1)
Caregiver's Name: _____ Date of birth: _____

Relationship to Child: _____

Address (if different from contact information)

_____

Cell Phone: _____

Best time to call: _____

Occupation: _____ Employer: _____ How long? ____

Child's Caregiver (2)
Caregiver's Name: _____ Date of birth: _____

Relationship to Child: _____

Address (if different from contact information)

_____

Cell Phone: _____

Best time to call: _____

Occupation: _____ Employer: _____ How long? ____

Relationship of Caregivers
Married Living together Widowed Separated Divorced
Date of Separation:

Who lives in the home with the child?

Name	Age	Relationship to Child

Please describe your concerns about your child and your reason for seeking help.

When did you first notice these concerns?

What are your child's strengths?

Briefly describe your child's behavior at home.

How does your child get along with siblings?

What special activities do you do as a family?

School Environment and Behavior

Briefly describe your child's behavior at school.

Briefly describe your child's academic strengths.

Briefly describe your child's academic areas to improve.

How do teachers and non-family members describe your child?

Briefly describe your child's feelings about school.

If your child has an IEP or 504, what are the goals it is currently addressing? Is your child making progress on these goals?

Medical and Developmental History

Please describe your child's general health.

Please list any medication your child currently takes and what it is for.

Medication	*Taken for what reason?*	*Dosage*

Please describe any serious illness, accidents or injuries.

Please describe any known traumatic events or significant stressors in your child's life. Include any known neglect or abuse.

Please list any known allergies, especially food.

Special Concerns

Please check any past or present concerns about your child:

Learning difficulties	Problems with peers	Problems with teachers
Academic challenges	Rule breaking	Aggression toward others
Drug/alcohol use	Anger	Social Skills
Anxiety	Depression	ADHD
Other:		

What are your goals for your child during therapy?

Please share any other information that you feel is important and beneficial to the success of your child counseling

_____

Printed Name

_____ _____

Signature of parent/guardian Date