Melanie Stone, PhD HSPP

CHILD & ADOLESCENT CLIENT INTAKE FORM

Child's full name: _____ Date of birth: _____
Home address: _____ City, state, ZIP: _____
School name: _____ Grade level: _____
Person completing this form: _____ Relationship to child: _____

Parent / Guardian 1

Name: _____ Relationship to child: _____
Address: _____ City / State / Zip: _____
Primary Phone: _____ Email: _____
Employer: _____ Spouse/Partner Name: _____

Parent / Guardian 2

Name: _____ Relationship to child: _____
Address: _____ City / State / Zip: _____
Primary Phone: _____ Email: _____
Employer: _____ Spouse/Partner Name: _____

I give Dr. Stone permission to contact me by: ☐ Phone call ☐ Voicemail ☐ Text ☐ Email

Child's current living arrangement: ☐ Two-parent household ☐ Shared custody ☐ Primarily with one parent/guardian
☐Grandparent/relative ☐ Foster/other caregiver ☐ Other_____
Are the child's parents separated or divorced? ☐ Yes ☐ No
Who has legal authority to consent to treatment?
_____
Is there a current custody agreement or court order relevant to treatment? ☐ Yes ☐ No
If yes, please provide a copy or explain anything Dr. Stone should know:
_____

Child's Physician: _____ Date of last visit:_____

Please list any significant health problems your child is experiencing:
_____
_____

Please list any medications your child is taking and who prescribed them:
_____

Has your child had counseling or psychotherapy previously? ☐ Yes ☐ No
If yes, when and with whom?
_____

Religious/spiritual background or affiliation, if relevant to the child or family:
_____

School & Development

School district: _____
Does your child have an IEP or 504 Plan? ☐ Yes ☐ No ☐ Unsure
Any current academic, attendance, behavioral, or social concerns at school? ☐ Yes ☐ No
If yes, please describe:
_____
_____

Please check any concerns that are affecting your child now:

☐ Worry/anxiety
☐ Panic attacks
☐ Social discomfort
☐ Racing heart
☐ Poor appetite
☐ Headaches
☐ Sleep disturbance
☐ Obsessive thoughts
☐ Feeling fearful
☐ Outbursts of temper
☐ School avoidance
☐ Defiance
☐ Eating concerns
☐ Grief/loss
☐ Sadness/depressed mood
☐ Hopelessness
☐ Crying easily
☐ Fatigue
☐ Feeling inferior
☐ Poor concentration
☐ Poor memory
☐ Health concerns
☐ Friend/peer relationships
☐ Irritability/anger
☐ Decline in grades
☐ Aggression
☐ Separation anxiety
☐ Trauma-related symptoms
☐ Religious/spiritual concerns
☐ Difficulty making decisions
☐ Family problems
☐ Disturbing memories/flashbacks
☐ Bad dreams/nightmares
☐ Loss of interest or pleasure
☐ Thoughts of harming others
☐ Thoughts of death
☐ Self-harm behaviors
☐ Alcohol/drug use
☐ Attention/concentration problems
☐ Bullying/peer conflict
☐ Excessive screen/social media use
☐ Other

What are the main reasons your child is coming into counseling at this time?

_____
_____
_____

What changes do you hope to see as a result of counseling?

_____
_____
_____

Has your child experienced a significant loss, trauma, frightening event, or other difficult life experience that may be relevant to counseling? (Please share only what you feel comfortable including here.)

_____
_____

In general, how would you describe your child's relationships within the family and home environment?

_____
_____

Is there a history of mental health problems in your family? ☐ Yes ☐ No ☐ Unsure
If yes, which family members and what concerns were present?

_____
_____

Are any of those family members currently taking medications for those concerns? ☐ Yes ☐ No
If relevant, please explain:

_____

How were you referred to Dr. Stone?

_____

Optional referral-source acknowledgment: If appropriate, I give Dr. Stone permission to let my referral source know only that we followed up on the recommendation for services. ☐ Yes ☐ No

Parent/Guardian signature: _____ Date: _____

Questions for Dr. Stone

Do you have any other questions or concerns you would like to discuss today?

_____
_____
_____