

**TERESA KHOUW, MA, LPC, RPT
CHILD INTAKE**

Child's Name: _____ **Age:** _____ **DOB:** _____

Sibling: _____ Age: _____

Sibling: _____ Age: _____

1. Parent's Name: _____

Address (City, State, Zip) _____

Marital Status: _____ Male/Female: _____

Phone: Home: _____ Cell: _____

Email: _____ Is it ok for counselor to email you? _____

2. Parent's Name: _____

Address (City, State, Zip) _____

Marital Status: _____ Male/Female: _____

Phone: Home: _____ Cell: _____

3. Step Parent(s)/Guardian(s): _____

Address (City, State, Zip): _____

Marital Status: _____ Male/Female: _____

Phone: Home: _____ Cell: _____

Parent Information:

Are there any other agencies involved with the family (CPS, Custody Courts, etc.?)

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements.)

Is ex-spouse (biological parent) aware that you are bringing their child to counseling? Yes _____ No _____

www.ChildCenteredCounseling.net

972 365 8165

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If no, please explain: _____

Child Information:

Child lives with: _____

School child attends: _____ Grade: _____ Teacher: _____

Has child received psychiatric treatment? No ___ Yes ___ Psychiatrist's Name: _____

Has child received counseling previously? No ___ Yes ___ Counselor's Name: _____

Significant Medical Problems: _____

Medications currently prescribed: _____

Pediatrician Name & Phone: _____

Please describe what concerns you have regarding your child: _____

How long has the problem existed? _____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems, in the last several years?

What attempts have been made to resolve the difficulties? _____

On the following page, please check the symptoms that the child is currently experiencing. Please indicate duration and severity.

<i>How Long</i>	<i>Severity of symptom</i>			
	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
	<i>0</i>	<i>1</i>	<i>2</i>	<i>3</i>

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Sadness or Depression		
Suicidal Thoughts		
Sleep Problems		
Changes in Appetite		
Weight Change		
Inability to Concentrate		
Obsessive thoughts		
Tension and Anxiety		
Panic Attacks		

Memory Problems		
Compulsive Behaviors		
Hostility		
Acts of Violence		
Social Isolation		
Body Pains		
Bed Wetting		
Other:		