A BEAUTIFUL MIND
Counseling and Psychological Services

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Child Intake Sheet

Date____________

Child's Name:____
Last First Middle Date of Birth

Address____
Street City State Zip Code

Child lives with (include all members of the household):

Names Relationship Birthdate

____

____

____

____

____

If divorced, what is the custody arrangement:

☐ Sole Custody ☐ Legal Custody ☐ Physical Custody ☐Joint Physical Custody

☐ Joint Legal Custody Other:____

Parent /Guardian Information

Name: ____
Last First Middle Birthdate

Address____
Street City State Zip Code

Home Phone: (____)_______________ Cell: (____)______________________ Soc. Sec#________________

Marital Status: (Circle One) Married Single Separated Divorced Widowed

Turn over for next page ->

Spouse's Name ___________________ Birthdate _____________ Soc. Sec. #_________________

Address (if different from above)____
Street City State Zip

Emergency Contact____

____(_____)______________________________________
Address Telephone #

SCHOOL INFORMATION

School child is currently attending: ____
Name Address

Grade:______ Are school grades and/or school behavior a concern?_____________________________

Comments:____

____

____

____

PARENT/GUARDIAN EMPLOYMENT

Name:____

Employer:_____________________________________ Address:_________________________________

May you be contacted at work?________ If Yes, Phone #: (____)_________________________________

Job title: ____

SPOUSES EMPLOYMENT

Name:____

Employer:_____________________________________ Address:_________________________________

May you be contacted at work?________ If Yes, Phone #: (____)_________________________________

Job title: ____

FINANCIAL RESPONSIBILITY

Who is financial responsible for the bill and how will it be paid?__________________________________

Name of Insurance Company:_______________________________ Phone:_________________________

Group #____________________ ID#____________________ Copay $______________ Deductible $______________

Turn over for next page ->

HEALTH INFORMATION (Child's)

Primary Care Doctor: ____

Phone #:______________________________Address: ______________________________

Last physical exam:____________________Current health: (Good) (Poor) (Average)

Allergies:____

Current medications, including dosage and reason for taking it:______________________________

____

____

____

Medications recently taken:____

Significant health problems:____

Previous counseling, therapy, or psychiatric treatment?______________________________

____

If yes, doctor, facility, or agency:____

____

(Include name and address if known)

By whom were you referred?____

Is this condition accident related?____

What do you see as the problem? ____

____

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