A BEAUTIFUL MIND
Counseling and Psychological Services

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Child Intake Sheet

Date_____

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

Age: _____Sex: M F Identified Gender:_____

Address_____
Street City State Zip Code

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

Names	Relationship	Birthdate	Age

If divorced, what is the custody arrangement:
□ Sole Custody □ Legal Custody □ Physical Custody □Joint Physical Custody

□ Joint Legal Custody Explain:_____

Parent /Guardian Information

Name: _____
Last First Middle Birthdate Age

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 ->>

May you be contacted by email? _____ If yes, email address_____

Would you like reminder notifications? _____If yes please choose one of the following methods:

By text (data charges may apply depending on your plan): Cell (_____)_____

Automated phone call: Phone (_____)_____

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: _____

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FINANCIAL RESPONSIBILITY

Who is financially responsible for the bill and how will it be paid?_____

Who is the insured? (person who the policy is under/through) Name:_____

Insured Date of Birth and relationship to the client:_____

Insured Employer:_____Address:_____

Name of Insurance Company:_____Phone:_____

Group # ID# Copay $ Deductible $

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:_____

Please list any previous counseling, therapy, or psychiatric treatment? (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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