Ebenezer Counseling Services

Child / Adolescent Intake Form

(If child, may be completed by adult)

Date _____

Name _____

Address _____

City _____ State _____ Zip_____

Home Phone _____Client Cell # _____

Social Security Number _____ Date of Birth _____

Age _____ Sex _____ School _____ Grade level _____

Clubs / groups / sports you're active in _____

Do you work? _____ Employer _____ Total hrs/week _____

Work # _____ May we contact you at work? _____

Presently living with: Parents____ Roommate____ Alone____ Other_____

Father's employer _____ Work phone _____ Cell _____

Mother's employer _____Work phone _____ Cell _____

Who will be responsible for payment of bill? _____

Relationship to patient? _____ Address if different_____

Will you be using insurance? _____ Primary Insurance Co. _____

ID#_____Group #_____Relationship_____

Policyholder_____DOB_____SSN_____

Denomination or Church _____

Active _____ Inactive _____

Family Members:

Relationship	Name	Age	Grade in school last completed	Occupation if out of school	Check if still living with you
Father					
Mother					
Step-mother					
Step-father					
Brothers					
Sisters					

- Please continue on back-

CONFIDENTIAL

Describe any physical problems you have that require medication or physical care:

_____

Medication currently using: _____

Are you currently receiving medical treatment? Yes _____ No _____

Physician or health care provider _____

Previous Therapy / Hospitalization Yes _____ No _____

Where / with whom _____
Name Address Dates

Problem Areas: In the following list, place a check mark next to each item which identifies an area of concern to you. Place **two checks** by those items which are most important. *You may add written comments in the additional space below.*

1. _____ Anger / temper
2. _____ Depression
3. _____ Fearfulness / nightmares
4. _____ Unhappy most of the time / sadness
5. _____ Worry (constant)
6. _____ Family problems (siblings / parents)
7. _____ Family transitions (divorce, remarriage, birth)
8. _____ Responsibilities / chores
9. _____ Physical problems
10. _____ Religious / spiritual concerns
11. _____ Thoughts of suicide / hurting others
12. _____ Trouble making decisions
13. _____ Use of alcohol
14. _____ Use of drugs / cigarettes
15. _____ School concerns (grades, peer interaction)
16. _____ Problems with social relationships (friends)
17. _____ Sexual concerns
18. _____ Victim of uninvited sexual advances
19. _____ Other (specify) _____

Additional comments regarding checked areas:

Is there any history of adoption in your family?

_____

_____

In your own words, briefly describe the main problem which prompted you to seek therapy at this time.

_____

_____

Is there anything else which you believe might be important for your therapist to know at this time?

_____

_____