



ENVISION

COUNSELING AND CONSULTING

Child and Adolescent Intake

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____

Street City State Zip

Residence Phone: _____ OK to leave a message? Yes/ No

Cell Phone: _____ OK to leave a message? Yes / No

Work Phone: _____ OK to leave a message? Yes / No

Social Security Number (optional): _____

Marital Status of Parents (circle one): Together Never Married Single Married
Separated Divorced Widowed

Mother's Name: _____ Date of Birth: _____

Occupation: _____ Employer: _____

Home Address: _____

Street City State Zip

Work Address: _____

Street City State Zip

Father's Name: _____ Date of Birth: _____

Occupation: _____ Employer: _____

Home Address: _____

Street City State Zip

Work Address: _____

Street City State Zip

Siblings (names and ages): _____

Other Significant People (names and ages): _____

Emergency Contact:

Name: _____

Phone: _____

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School: _____ Grade Level: _____
Please list any illnesses and/ or hospitalizations that you may have had: _____

Previous psychotherapy: _____

Current Medications: _____

Briefly state your (or your parents') reasons for coming (or bringing you) today: _____

Referred by: _____

Insurance Company Name: _____

Insurance ID: _____ Group Number: _____