

## Intake Form for Child and Adolescent Patients

### Child's Identifying Information

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Religion: \_\_\_\_\_ Sexual Orientation: \_\_\_\_\_

Gender Identity: \_\_\_\_\_ Preferred Gender Pronouns: \_\_\_\_\_

Current School: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Referred to therapy by: \_\_\_\_\_

### Parent/ Guardian Identifying Information

Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Parent's Relationship Status:

- ☐ Single ☐ Cohabiting ☐ Married ☐ Never Married ☐ Divorced  
☐ Separated ☐ Widowed

If divorced or separated, who has legal custody? \_\_\_\_\_

### Emergency Contact Information

Please identify an emergency contact other than the parent/guardian.

Name of Emergency Contact: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

I, \_\_\_\_\_, agree for therapist to contact the above  
(print name)  
person in the case of an emergency.

Signature of Client/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### Insurance Information

Insurance Company: \_\_\_\_\_

Patient's ID #: \_\_\_\_\_

Policy Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_