293 Byrd Mill Road • Louisa, VA 23093
emPOWER Phone: 804-601-0171 • Cedar Row Farm Phone: 540-223-0837

Child-Adolescent Intake

Demographic Information

Child's Name:		Age:	DOB:
Address:			
Parent Telephone numbers:	Home:	Work:	Cell:
Can I leave a message at the above number?	YES/NO	YES/NO	YES/NO
Preferred way to be contacted (circle one):	Home	Work	Cell
May I contact you by E-mail? YES/NO		Email:	

In case of an emergency, who may I contact?

Name:	Relationship:	Phone Number:

Family Information

Mother's Name: Occupation:	Father's Name: Occupation:
Step-parents? Name and relationship:	

Who does your child currently live with?		
Names	Age	Relationship to child

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Any other significant people in your child's life that are NOT living with your child?		
Names	Age	Relationship to child

Are child's parents'? Married Separated Divorced Widowed (please circle one)

Does anyone in the child's family been diagnosed with a mental illness? YES/ NO

If yes, please describe:

Is there anything else that you think would be important for me to know about your child, you, or your family?

Education

Child's School:	Grade Level/Teacher:
Does your child enjoy school: YES/NO	Favorite Subject:

Does your child have an Individualized Education Plan? YES/NO
If yes, what does the IEP include?

Has your child been identified for honors/gifted classes? YES/NO

Has your child experienced any of the following at school? (please circle all that apply)

Fighting	Suspension	Lack of Friends	Gang Influence
Problems with Academic Performance	Incomplete Homework	Poor Attendance/ Skipping Class	Detention
Behavior Problems	Poor grades	Other (Explain):	

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Please, use the space to provide any other additional information regarding your child's education or developmental history that you find significant:

Medical Information

Pediatrician's Name:	Phone:
Is child under the care of another medical specialist? YES/NO If yes, type of specialist and name:	Phone:
Did your child meet developmental milestones as expected? YES/NO If no, please explain?	

Please list any chronic illness, disabilities, or medical conditions that you have been diagnosed with:

Illness/Disability	Dates

List all medications you are currently taking:

Medication	Dosage	Reason

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Therapy/Psychiatric Experience and Needs

Is your child *currently* seeing another therapist? YES / NO If yes, name and contact information?			
Has your child ever been in therapy in the past YES/ NO			
If yes, please fill out the following on your previous counseling experience(s)			
Therapist	Location	Dates	Reason
Has your child ever had a psychiatric hospitalization? YES/ NO			
If yes describe briefly and indicate dates and circumstances?			
Is your child under the care of a psychiatrist: YES/ NO			
Name and Practice Name:		Phone Number:	

Briefly describe your reason(s) for seeking therapy at this time:
What goals do you hope you child will accomplish during the therapy process?
Is there anything else you would think would be important for me to know about your child and your family?