



Road 2 Resolutions PLLC
Professional Counseling

Child Intake Form

Name: _____ Date of Birth: _____ Age: _____

Race: _____ Birthplace: _____

Gender: Male _____ Female _____ Religion: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____

Referred by: _____

Name of Parent/Legal Guardian: _____ Phone # _____

Address: _____ City: _____ State: _____ Zip: _____

Sole Custody Joint Custody
Marital status of the child's parents _____

Name _____ Phone # _____ Relationship to client: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Person: _____ Phone Number: _____

Current Education Status:
School Attending _____ Grade _____

Are there other children living at home? ___ Yes ___ No
If yes, please give names and ages. _____

For what purpose are you seeking treatment for this child? _____

Has the child received counseling in the past? ___ Yes ___ No If yes, where? _____

Please explain any current or past medical conditions: _____

Please list any prescription medications the child is taking. _____

To your knowledge has the child ever attempted suicide? ___ Yes ___ No If yes, please explain:

To your knowledge has the child been a victim of physical/emotional or sexual abuse? Yes No
If Yes, please explain: _____

Parent/guardian Signature _____ Date: _____