Aquiline Counseling
Sandy Tudor, MA, LMHC
Child-Under 13 Years of Age Intake Sheet

Today's Date: ___________________

To be filled out by the parent

Client/Child Name; First_________________________ Last______________________________Middle Initial_____

Parent Names: First______________________________ Last______________________________Middle Initial_____

First______________________________Last______________________________Middle Initial______

Address____City________________________Zip__________

Home Phone____________________ Cell Phone____________________Cell Phone__________________________

Work Phone____________________Email____

Acceptable Forms of Communication & Leaving Messages: (check those that are acceptable)

Home Phone____ Cell Phone____ Work Phone____ Email____ Texting____

Child's Age____ Date of Birth__________________________________

PARENTAL History:

Relationship Status: Single____ Married____ Separated____ Divorced____ Widowed____ Cohabitating____

Other__________________

Length of current marriage or relationship___________ Number of divorces____________________________

Number of previous cohabitations__________________ If divorced, for how long?___________________________

Separations___________________ Affairs____

Other/Comments____

Child's Siblings:

1. Name, age,gender____
2. Name, age, gender____
3. Name, age, gender____
4. Name, age, gender____

Additional/Comments____

Who does the child live with?____

Pets?____

Please indicate major life stressors for the family in the past 12 months or so:

Death of a family member or close friend______ Divorce/Separation______ Job Issue_______

Serious personal illness or injury_______ Major illness or injury in family_____ Gain of new family member_____

Move____ Financial____ Other____

Please indicate any of the following the child has experienced?

Death of Mother____ Age at occurrence_____

Death of Father____ Age at occurrence_____

Death of Sibling____ Age at occurrence_____ Siblings age____

Desertion by Mother______ Age at occurrence_____

Desertion by Father______ Age at occurrence_____

Divorce of Parents_______ Age at occurrence_____

Separation of Parents_______ Age at occurrence_____

Has the child experienced: Sexual abuse____ Emotional abuse_____ Physical abuse_____

Neglect_____ Violence in the family_____ Mental illness of a family member______

Other trauma____

Treatment Information:

Has the child ever received psychological or psychiatric counseling in the past? Yes____No____

When?____

From Whom?____

Purpose____

Your opinion of results____

Has the child ever been diagnosed with a mental health issue? Yes_____ No_____

What was the diagnosis?____

Has the child ever been prescribed medication for a psychiatric or emotional concern? Yes_____ No_____

Name of medication?____

What were the results of the medication?____

Is the child currently taking psychotropic medication (such as ADHD medication, antidepressants, etc)? Yes____No____

Name and dosage of the medication____

Has the child ever been hospitalized for a psychiatric or emotional health reason? Yes____ No____

Has the child ever been in a drug or alcohol treatment program? Yes____ No____ Inpatient____ Outpatient____

Where?____

Outcome?____

Medical Information

Primary Care Physician or Clinic____ Phone__________________________

Date of latest physical exam___________________ Major surgeries__________________________________

Chronic Illnesses____

Injuries____

Other pertinent medical____

Other Current Medications (Name, dosage, frequency)______________________________________

Overall health: poor___fair___ good____ excellent____

To the best of your knowledge does your child use:

Tobacco: Yes____ No_____ What type?: cigarettes____ chewing tobacco _____ other______________

Marijuana: Yes_____No_____ What type? Smoked____ edibles__________ other __________________

Alcohol consumption? Yes____No____

Street drugs or misuse prescription drugs? Yes____ No____

Name of drug(s) and frequency____

Compulsive/addictive behaviors? yes___ no___

gambling______ sex______shopping_____ gaming______internet________other__________

Education background

School:____Grade: _________

Does the child like school: Yes___ No___

Has the child been bullied: Yes ____ No____

Has the child bullied others: Yes ____ No ____

Family Spiritual Resources

How important is spirituality in your life? Not important___ Somewhat important___ Significant___ Very significant___

Optional: Religious affiliation / faith / beliefs / denomination ____

Please describe the main concern(s) from parent's point of view____

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What are the child's goals for counseling?(child's own words if possible)__________________________________

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What are the parent's goals for the child's counseling? ____

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Insurance Information

Note: Clients are financially responsible for annual deductibles, co-insurance and/or co-pays not covered by insurance.

Insurance Company ____ Phone _______________________

(a copy of insurance card and personal identification of the parent required at time of first visit)

Client relationship to policy holder: Child _____ Other ______

Policy ID number ____________________________________ Group number ____________________________

Name of Policy Holder ________________________________Date of Birth of Policy Holder____________________

Address if different than client ____Phone__________________

Employer____

Is there any other health benefit plan? Yes ___ No____

*I agree to permit **Sandy Tudor and Aquiline Counseling LLC** to release to my insurance company and/or their representatives any information necessary for processing my insurance claims. This information may include: personal information listed above, diagnosis, dates of office visits, types of service, and the amount of charge. My signature also indicates that the information I have provided is true and complete. I understand that failure to provide complete information will result in my being held personally responsible for all charges incurred**. I understand that I am held financially responsible for unreimbursed charges not covered by the insurance policy.***

Cash Paying Client: I understand that payment is due at the time services are rendered.

Parent's Signature____Date____________