Family Service Agency
Strengthening Individuals & Families

Child Intake Form

Name of Child: Last______________________________ First___________________ MI_____ Birth Date____________

Child's Preferred Pronouns: ________________________________

Primary Guardian: Last___________________________ First_____________________ MI_____ Birth Date____________

Circle One: Biological Mother Biological Father Adoptive Parent Foster Parent Other: ________________

SSN__________________ Phone: Cell________________ Home___________________ Email____________________

Address ______________________________________City____________________ State ______ Zip ______________

Employer ____Phone: ___________________________

Preferred Contact: Home Cell Work Email Best Time to Contact: _________________

Secondary Guardian: Last____________________________ First________________ MI____ Birth Date __________

Circle One: Biological Mother Biological Father Adoptive Parent Foster Parent Other: ________________

SSN____________________ Phone: Cell_________________ Home_________________ Email__________________

Address _______________________________________City____________________ State ______ Zip ______________

Employer ____Phone: ___________________________

Preferred Contact: Home Cell Work Email Best Time to Contact: _________________
Circle one

Custody Arrangement: Married Joint custody Shared custody No arrangement (Never married)
Circle one
No arrangement (Divorced) Other: ____

Are there any current legal issues/Custody Agreements? NO YES: _______________________________________

Treatment History

Is the client currently or previously receiving mental health treatment? YES or NO If yes, where__________________

Are you willing to sign a Release of information? YES or NO

Is the client on any medications?

Name of Medication	Purpose of Medication	Dosage	Effective?

Recent health problems and/or hospitalizations?

Date	Concern	Other

Do you have concerns about any of the following? *Please circle*

Anger Management	Anxiety	Sexual Behaviors	Severe Mood Swings
Eating Problems	Fears	Hyperactivity	Behavioral Changes
Sleeping Problems	Depression	Alcohol/Drugs	Problems at School

Other: ____

Household Information

Household size: ________________________________ Household income: ____________________________

Children Living in the Household:

Last Name	First Name	Age	Gender	Relationship to Client

Others Living in the Household:

Last Name	First Name	Age	Gender	Relationship to Client

Person Completing Form: ____