

# Center for Health, Learning & Achievement

310 Waymont Court, Unit 104

Lake Mary, FL 32746

(407) 718-4430

(321) 363-1041 Fax

## Counseling Intake Form

Thank you for taking the time to fill out this form. Please fill it out as completely as possible as it will help me begin to learn about your child's strengths as well as your areas of concern. This form will be kept confidential and remain in your child's secured clinical file. This information can only be released to others with your written permission.

### Child/Family Information

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address:

\_\_\_\_\_  
\_\_\_\_\_

Mother's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mom's Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Dad's Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Primary Contact Person and Best Way to Reach You? \_\_\_\_\_

Parents' Marital Status: (if separated, divorced or deceased how long? If remarried, how long?

How has your child responded?)

\_\_\_\_\_  
\_\_\_\_\_

Siblings (Please list names and ages). \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have there been any recent deaths or major life changes in the family recently? If yes, please describe. \_\_\_\_\_

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Is anyone in the family diagnosed with a mental health illness? If yes, please explain. \_\_\_\_\_

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Child's Diagnosis (if applicable).

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Please list all support services child is receiving now or has received: (speech/language, occupational therapy, educational accommodations, etc.).

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Does your child take any medications? If so, please list medication and purpose of medication.

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Does your child have any medical conditions/concerns? \_\_\_\_\_ If yes, please describe.

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**School Information**

Name of School: \_\_\_\_\_

Grade: \_\_\_\_\_

Has your child ever been held back or advanced a grade? If yes, please explain. \_\_\_\_\_

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What type of school program is your child currently in? \_\_\_\_\_

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Please check all areas of concern that affect your child's social/emotional/academic success.

- behaving impulsively
- exhibiting anxiety
- having temper tantrums
- lacking eye contact
- exhibiting non-compliance
- separation anxiety
- adapting to new situations
- taking turns
- interrupting conversations
- reading facial expressions
- understanding social cues
- exhibiting bullying behavior
- target of bullying behavior
- listening
- following directions
- contributing (off topic) to conversations
- exhibiting hurtful behaviors (towards self, siblings, parents or others)
- initiating/maintaining conversations
- self-esteem problems
- legal concerns
- substance use/abuse
- other

Please explain areas of concern:

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What are your goals for your child through this counseling experience?

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Has your child participated in counseling before? If so, was his or her experience beneficial?  
What was helpful?

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What are your child's strengths? Special interests or talents? Extracurricular activities?

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Is there anything else you would like me to know about your child?

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Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete this form, sign and either scan or fax before your first appointment.