GRATEFUL HEART
HOLISTIC THERAPY CENTER

Biographical Information – Intake Form- Child/Adolescent

Please fill out this biographical background form for your child as completely as possible. Information is confidential as outlined in the Psychotherapy Agreement. If you do not desire to answer any question, merely write, "Do not care to answer." If certain questions do not apply to your child, please leave them blank.

Name of Child:_____Nickname:_____Date:_____

Child Date of Birth: _____ Age _____Place of Birth: _____ Gender _____

Child's Address: _____City/State_____Zip_____

Telephone Contact: Home #_____Cell #_____Email _____

Person Completing Questionnaire: _____Relationship: _____

Legal Guardian _____ Relationship _____ Phone _____

Address (if different than above) _____

Marital Status of Parents _____

Joint Custody? Y N If yes, please include name and phone #, and preferred contact of all who have joint custody

Referral Source: _____

REASON FOR SEEKING THERAPY? - Please be as specific as possible, using back of page if needed

_____

_____

_____

_____

_____

_____

_____

FAMILY

PRESENT PRIMARY CAREGIVERS (ex – mother, father, grandparent, adoptive parent)

Name	Age	Occupation	Relationship

OTHER CHILDREN IN THIS CHILD'S HOME

Name	Age	Relationship to Child	Grade

OTHER ADULTS LIVING IN CHILD'S HOME

Name	Age	Relationship to Child

HISTORY

Please describe who were the child's primary caregivers growing up and residence, from birth to present, as well as other important figures in the home

RACIAL/ETHNIC/CULTURE/IMMIGRATION BACKGROUND – Describe relevant information for child, parents, and community

ABUSE HISTORY/STRESSORS – Describe any exposure to abuse, neglect, and violence

PREGNANCY/CHILDBIRTH – Briefly describe the child's mother's pregnancy or childbirth, including medications or drugs used by mother or father during pregnancy or conception

DEVELOPMENT – Please rate how you view child's development relative to their same-age peers.

	Below Average	About Average	Above Average
Social			
Physical			
Language			
Intellectual			
Emotional			

WHAT DO YOU SEE AS THE CHILD'S STRENGTHS?

WHAT DO YOU SEE AS THE CHILD'S CHALLENGES?

HOW WOULD YOU DESCRIBE HOW YOU AND THE CHILD RELATE?

SUICIDAL IDEATION AND/OR ATTEMPTS AND HOSPITALIZATIONS – Describe dates and circumstances briefly

PAST/PRESENT PSYCHOTHERAPY - Specify name of therapist, plus dates of service and type of therapy, reason for therapy

Therapist	**Dates**	**Type**

MEDICAL DOCTOR (S): Name: _____Phone_____

Address: _____ Date of Most Recent Physical: _____

PAST/PRESENT MEDICAL CARE - Please list any major surgeries, accident, hospitalizations and/or illnesses

CURRENT PHYSICAL CONCERNS (e.g. headaches, pain, stomachaches, food allergies, chronic illnesses)

PHYSICAL CONCERNS IN THE PAST YEAR

MEDICATIONS

Medication	**Purpose**	**Dosage**	**Frequency**

WHAT ACTIVITIES DOES THE CHILD PARTICIPATE IN? - include # of hours if possible

School (type/grade) _____

Family/Community _____

Physical Activities _____

Other organized activities _____

Time Spent with Homework Outside of School _____

Free time/Interests _____

_____

_____

Online time _____

PLEASE DESCRIBE ANY FAMILY HISTORY OF ALCOHOLISM, MENTAL ILLNESS OR VIOLENCE:

IS CHILD OR FAMILY INVOLVED IN ANY CURRENT OR PENDING CIVIL OR CRIMINAL LITIGATION/S, LAWSUIT/S OR DIVORCE OR CUSTODY DISPUTE/S? If you answer yes, please explain:

Please add below, on the other side of the page or on a separate page any other information you would like me to know about you and your situation.