OLIVE BRANCH COUNSELING, LLC

Kelli Hauer-Skorman and Associates
9100 Conroy Windermere Road, Windermere, FL 34786
407-612-5808 www.olivebranchcounselingorlando.com

CLIENT THERAPY INTAKE FORM

Please complete on behalf of your child

Name of person completing this form: _____

Your relation to the child: _____

Phone: _____ Email: _____

Name of other parent/legal guardian: _____

Phone: _____ Email: _____

Child's First Name: _____ **Last Name:**_____

Age: _____ Birth day: _____ Month:_____ Year:_____

Ethnicity: _____ Religion: _____ Sex/gender: _____

Home address: _____

Who does your child live with? _____

ACADEMIC INFORMATION:

Name of Child's School: _____ Grade/year: _____

Program: _____ Typical Grades: _____

HOW DID YOU FIND THIS CLINIC:

☐ Word of Mouth ☐ I'm a former client ☐ Psychology Today ☐ Google

☐ Other: _____

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METAL HEALTH TREATMENT HISTORY:

Has your child ever been hospitalized for psychological or psychiatric reasons? Yes No

If yes, please describe when and where, and for which reasons.

_____

_____

_____

Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment)

_____

_____

_____

CURRENT HABITS:

Please describe your child's **current habits** in each of the following areas:

Smoking: _____

Drinking: _____

Drug Use: _____

TV Use: _____

Internet Use: _____

Video Game Use: _____

Caffeine Intake: _____

Exercise: _____

Eating: _____

Sleeping: _____

Fun and Relaxation: _____

Chores and Responsibilities: _____

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RELATIONSHIPS:

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother: _____

Biological Father: _____

Step-parents: _____

Legal guardians: _____

Siblings: _____

Extended family: _____

Your children: _____

Friends: _____

Romantic partner(s): _____

Colleagues or classmates: _____

Total number of close, supportive relationships: _____

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that your child has been experiencing:

	Yes	No	If yes, please describe:
A recent move or change in school?	○	●	
Abuse or neglect?	○	●	
Bullied or ignored by peers?	○	●	
Academic difficulties?	○	●	
Weight control issues?	○	●	
Sexual orientation concerns?	○	●	
Self-injury?	○	●	
Death or illness of a loved one or pet?	○	●	
Family conflict?	○	●	
Separation or Divorce?	○	●	
Other?	○	●	

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REASON FOR YOUR CHILD'S VISIT

_____

_____

_____

_____

_____

_____

How intense is your child's emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe: _____

_____

Overall, how much do the problems affect your child's ability to perform at school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe: _____

_____

When did these problems start? What was going on in your child's life at that time?

_____

_____

_____

_____

Printed Patient/Legal Guardian Name: _____

Signature: _____ **Date:** _____

Typing your name replaces your manual signature.