momentum
mental health

7261 S. Broadway, Suite 101A
Littleton, CO 80122

Phone: (720) 445-5992
Email: robin@momentummentalhealth.com

Child Intake Form

Please provide the following information for our records. Information you provide here is held to the same standards of confidentiality as our therapy. **Please print out this form and bring it completed to your first session OR allow yourself thirty minutes prior to your appointment to complete the form in the office.**

Parent/Guardian Information

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Local Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) _____ Cell/Other Phone: ( ) _____

Work Phone: ( ) _____ E-mail: _____

May we call and leave messages at home? □ Yes □ No On cell? □ Yes □ No At work? □ Yes □ No
May we email you? □ Yes □ No

Marital Status: □ S □ M □ D □ W No. of Marriages: _____ Date of Divorce/Separation: _____

If Divorced, Contact Information of Other Custodial Parent:

Name: _____ Phones: _____

Address: _____ Email: _____

Name(s) of Siblings and Step-Siblings:

_____ DOB: _____ □ M □ F

_____ DOB: _____ □ M □ F

_____ DOB: _____ □ M □ F

_____ DOB: _____ □ M □ F

How much contact per week do you see the child coming for treatment?

_____

How Did You Hear About Momentum Mental Health? _____

Client Information (Child Coming For Treatment)

Name: _____
(Last) (First) (Middle Initial)

Local Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: ( ) _____ Cell/Other Phone: ( ) _____

E-mail: _____

May we call and leave messages at home? □ Yes □ No On cell? □ Yes □ No May we email? □ Yes □ No

Child is currently living with: _____

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Grade in School: _____ School: _____

Activities/Interests: _____

_____

Medical History

How would rate the child's current physical health? □Excellent □ Good □ Fair □ Poor

Is the child currently complaining of any physical problems? □ Yes □ No

If Yes, Please Explain: _____

Please list any medical conditions/disabilities/learning disabilities:_____

_____

Previous Hospitalizations: Date: _____ Reason: _____

Date: _____ Reason: _____

Daily Medication(s)	Prescribing Physician

Pediatrician/Family Physician: _____ Phone: _____

Counseling and Psychiatric History

Previous counseling? □ Yes □ No If yes, for how long? _____ When? _____

For what reason? _____ Name of Counselor: _____

Has the child ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, what type? _____

Has the child ever been prescribed psychiatric medications? □ Yes □ No If yes, please list:

Daily Psychiatric Medications and Dosage	Prescribing Physician

Has anyone in the family ever been diagnosed with or treated for any type of mental illness? □ Yes □ No

If yes, what type? _____

_____

Reasons for Seeking Help

What concerns have brought the child to counseling today? _____

_____

Where are these concerns causing the most problems for the child?

□ Home □ School □ Social □ Other _____

When did these concerns begin to be a problem for your child? _____

What concerns about the child have been identified by others?_____

Please indicate which of the following are currently problems for the child:

□ Crying Spells
□ Excessive Fear/Anxiety
□ Bullying/Picking Fights
□ Hearing Voices
□ Lack of Motivation
□ Decreased/Increased Appetite
□ Difficulty Making or Keeping Friends
□ Obsessions/Compulsions
□ Cutting
□ Hyperactivity
□ Refusal to Respond to Authority
□ Nightmares
□ Difficulty Separating from Family Members
□ Tantrums
□ Lack of Self-Confidence
□ Loss of Interest in Usual Activities
□ Insomnia/Hypersomnia

Is there anything else that you would like for me to know today? _____

_____