

**Restoration Counseling Service**  
CHILD / TEEN INTAKE FORM

Please provide the following information and answer the questions below. Note that the information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session. Date: \_\_\_/\_\_\_/\_\_\_

Child's Name: \_\_\_\_\_, \_\_\_\_\_  
(Last name) (First name) (Middle Initial)

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Grade: \_\_\_  Male  Female

Name of School: \_\_\_\_\_ Attend Church?  Yes  No

Church Name (if any): \_\_\_\_\_ Religious Background: \_\_\_\_\_

Child's Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ May I leave a message?  Yes  No

Cell/Other Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ May I leave a message?  Yes  No

E-mail: \_\_\_\_\_ May I email you?  Yes  No

\*Please note: Email correspondence is not considered to be a confidential form of communication.

Referred by (if any): \_\_\_\_\_

**FAMILY INFORMATION**

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

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Regular Attender?  Yes  No

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ May I leave a message?  Yes  No

Cell/Other Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ May I leave a message?  Yes  No

Email address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\* If parents living apart or father's address different than the child's please fill in address below.

Father's Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

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

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_ Regular Attender?  Yes  No

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ May I leave a message?  Yes  No

Cell/Other Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ May I leave a message?  Yes  No

Email address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\* If parents living apart or father's address different than the child's please fill in address below.

Mother's Address: \_\_\_\_\_  
(Street and Number)

\_\_\_\_\_  
(City) (State) (Zip)

Who currently resides in the same house as the child? Please indicate everyone including any half or step siblings.

Name	Age	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

**MEDICAL & PERSONAL**

Has your child had any counseling before?  No  Yes

Previous Counselor/Therapist Name: \_\_\_\_\_

Dates - From: \_\_\_\_\_ To: \_\_\_\_\_ Outcome: \_\_\_\_\_

Date of Last Medical Exam \_\_\_ / \_\_\_ / \_\_\_

How would you rate your child's current physical health?

Poor  Unsatisfactory  Satisfactory  Good  Very good

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Has child been diagnosed with a medical disorder or learning disability?  Yes  No  
If so, please list: \_\_\_\_\_

Is your child currently taking any prescription medication?  Yes  No

If yes, what kind(s) \_\_\_\_\_

Does your child have an addiction?  Yes  No  Uncertain

Have they had any previous trauma? (Physical, Emotional, or Sexual Abuse, Etc.)

Yes  No  Uncertain

Has your child ever been arrested?  Yes  No

**BASIC INFORMATION**

What is the current family situation?

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How do the parents relate to each other?

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What is the parent's style of discipline?

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What are your expectations for this child?

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How is the child different from other members in the family?

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How does the child handle stress?

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Is there any other information that you think your counselor should know?

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PLEASE CHECK ANYTHING YOUR CHILD HAS EXPERIENCED IN THE  
LAST 12 MONTHS

- |   |   |
|---|---|
| <input type="checkbox"/> Death of Parent(s)                       | <input type="checkbox"/> Parent begins or ends work               |
| <input type="checkbox"/> Divorce of Parents                       | <input type="checkbox"/> Jail term                                |
| <input type="checkbox"/> Separation of Parents                    | <input type="checkbox"/> Starting or finishing school             |
| <input type="checkbox"/> Remarriage of Parent(s)                  | <input type="checkbox"/> Change in living conditions              |
| <input type="checkbox"/> Death of close family member             | <input type="checkbox"/> Revision of personal habits              |
| <input type="checkbox"/> Personal injury of illness               | <input type="checkbox"/> Change in parents work hours, conditions |
| <input type="checkbox"/> Fired from work                          | <input type="checkbox"/> Change in residence                      |
| <input type="checkbox"/> Change in family member's health         | <input type="checkbox"/> Change in schools                        |
| <input type="checkbox"/> Pregnancy                                | <input type="checkbox"/> Change in recreational habits            |
| <input type="checkbox"/> Sexual Abuse                             | <input type="checkbox"/> Change in social activities              |
| <input type="checkbox"/> Addition to family                       | <input type="checkbox"/> Change in sleeping habits                |
| <input type="checkbox"/> Change of financial status of parents    | <input type="checkbox"/> Change in number of family gatherings    |
| <input type="checkbox"/> Death of a close friend                  | <input type="checkbox"/> Change in eating habits                  |
| <input type="checkbox"/> Foreclosure of parent's mortgage or loan | <input type="checkbox"/> Vacation                                 |
| <input type="checkbox"/> Change in work responsibilities          | <input type="checkbox"/> Christmas season                         |
| <input type="checkbox"/> Sibling leaving home                     | <input type="checkbox"/> Minor violation of the law               |
| <input type="checkbox"/> Trouble with in-laws                     | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Outstanding personal achievement         | <input type="checkbox"/> Other: _____                             |

Thank you for taking the time to answer these questions to the best of your ability. This will assist greatly in making sure your time with your counselor is focused and productive.

After filling this form out as completely as possible, please bring it with you to your first appointment.

**Restoration Counseling Service**  
339 Cajon Street  
Redlands, CA 92373  
909-255-1250