

ACTSolutions

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CHILD/ADOLESCENT INTAKE

Child/Adolescent's name: _____ Age: _____ DOB: _____
School: _____ Grade: _____
Teacher: _____ Counselor: _____

Parent(s): _____
Home phone: _____ Work phone: _____
Address: _____
Street Apt. # City/State/Zip

If parents are divorced, please list non-custodial or joint-custody
parent: _____ Home phone: _____
Work phone: _____ Address: _____
Stepparent: _____

Years divorced: _____ date of divorce: _____
Age of child at divorce: _____

Please list siblings (Clarify if living in home by 'IN' beside name):

_____	Age: _____	DOB: _____	Gender: _____
_____	Age: _____	DOB: _____	Gender: _____
_____	Age: _____	DOB: _____	Gender: _____
_____	Age: _____	DOB: _____	Gender: _____

Please list step-siblings (Clarify if living in home by 'IN' beside name):

_____	Age: _____	DOB: _____	Gender: _____
_____	Age: _____	DOB: _____	Gender: _____
_____	Age: _____	DOB: _____	Gender: _____

Reason for seeking therapy for your child/adolescent:

*I acknowledge that I, _____, am legal guardian of _____
_____. This is to certify that I give permission to Deborah M.
Wade, MA, LMFT, LPC, of ACTSolutions to provide counseling to my
child/adolescent. Treatment may include any of the following: play therapy, individual
therapy and/or family therapy. I understand that it is my legal right to gain access to
my child/adolescent's records. I also realize that at times the nature and content of
such services may need to remain confidential.*

Signature of parent or guardian

Date