building blocks
Family Counseling

Main Address:
205 S. Skinner Ave. Unit B
Pooler, GA 31322
912-349-8043
www.buildingblocks.solutions

Child and Adolescent Intake Information

Intake Information for a Child under age 18

Name: _____

Child lives with _____

Address _____

If parents are divorced, who has legal custody of child? _____

Date of Birth _____ **Age** _____ **Sex** _____ **Gender Identity** _____

Place of Birth _____ **Was child adopted?** _____ **If so, at what age**

Parent's

Date of Birth _____ **Age** _____ **Sex** _____ **Gender Identity** _____

Employer: _____

Job Title: _____ **Last grade completed in school** _____

Church affiliation _____ **Active?** _____

Referred by _____

May I send a thank you note to the person who referred you? _____

If so, please sign and date below. Thank you.

Signature_____ **Date**_____

Parent (Circle one): **Married** **Single** **Separated** **Divorced** **Widowed** **Domestic Partners**

Number of years: Married _____ Separated _____ Divorced _____

Partner's (Co-parent's) name: _____ Age _____

Address: _____

Phone (home) _____Work _____Cell_____

Date of Birth _____ Last grade completed _____

Employer & Job Title: _____

Who has LEGAL custody of the child:
If parents have joint custody, who has the final medical tie-breaker:

If parents are divorced, our office needs a copy of the most recent court order showing primary custody or tiebreaker, or the consent of both parents.

Divorce, Separation, and Custody Agreements
Building Blocks Family Counseling will not be party to custodial, separation, or financial disputes relating to individuals with regard to minor children to whom services are provided. The individual who requests the counseling services and signs the financial agreement is responsible for any balance due. All co-pays, co-insurance, and deductible, if applicable, will be collected at the time services are rendered from the individual requesting the counseling services for the minor child/children. We expect consent from both parents for therapy services. The therapist will discuss the minor's therapeutic information with the accompanied parent with the time of the visit. Building Blocks Family Counseling will provide a copy of any records requested, all though we reserve the right to charge a fee. Both parents have access to the minor child's records, unless there is a court order that specifically mandates only one of the parents has the right to authorize treatment and release of the minor's records.

Siblings:

Name	Age	Full/Half/Step/Other	Lives with?

Any other people living in the home:

_____

Are you or have you been involved with the Department of Family and Children Services (DFCS), please specify:

_____

_____

Treatment/Medical History Please list any past treatment for psychological, psychiatric, medical, or counseling services the child has received. list all major illnesses, injuries, accidents, hospitalizations, allergies, or medical conditions.

Medications:

Chief concern Please describe the main difficulty that has brought you here:

Please indicate any issues or concerns with the following:

□**Eating**	□**Sleeping**	□**Potty Training**	□**Communication**
□**Behavioral**	□**Violence**	□**Self-harm**	□**Self-esteem**
□**Peer Relationships**	□**Academic**	□**Focus/Concentration**	□**Emotional**
□**Grief/Loss**	□**Anxiety/Fears**	□**Suicidal Ideation**	□**Trauma**
□**Adjustment**	□**Sexual**	□**Parent/Child Relat.**	□**Chores/Responsibilities**

Child's current school and grade: _____

Is your child currently receiving special education services? If yes, in what area? Repeated a grade?

Child's current hobbies, extracurricular activities:

Please describe anything else you feel is important for me to know:

Which adults are important in your child's life?

What children are important in your child's life?

What responsibilities does your child have?

How does your child handle school/daycare?

How does your child get along with adults?

How does your child get along with other children/siblings?

Describe your child's eating habits.

Describe your child's sleeping habits.

What is your child most afraid of?

What does your child get angry about?

What does your child get sad about?

What hurts your child's feelings?
