Jeffrey D. Emery, MMFT, LMFT-S
5189 Texas Ave, Abilene, TX 79605
325-232-7530 (office) 888-843-6404 (fax)
www.mosaicwellnessonline.com
jemery@mosaicwellnessonline.com

Child/Adolescent Intake Form Page 1

Please provide the following information about your child:

Child's Full Name: _____	Nickname: _____
Date of Birth: _____ Age: _____	Today's Date: _____
Parent(s) names or primary guardian: _____	Parent(s) contact telephone numbers: #1 :_____ Relationship: _____ #2 : _____ Relationship: _____ #3 : _____ Relationship: _____

Education History

What school does your child attend? _____	Teacher's Name: _____
Current Grade Level: _____	Has your child ever repeated a grade? Y / N If YES, which? _____
Favorite subject: _____	Least favorite subject: _____
Does your child receive special education services? Y / N	Does your child receive tutoring? Y / N
Is your child in a gifted/talented/honors program? Y / N	Does your child enjoy school? Y / N

Has your child experienced any of the following at school? (please circle all that apply)

Fighting Suspension Lack of Friends Gang Influence Learning Disabilities Incomplete Homework Drugs/Alcohol Poor Attendance Behavior Problems Detention Poor Grades

Has your child been the victim of bullying or bullied other children? Y / N If YES, please briefly describe:

Please use the space below to provide any other additional information regarding your child's education or developmental history that you find significant:

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Child/Adolescent Intake Form Page 2

Please provide the following information about your child:

Pediatrician's Name: _____	Phone: _____
Is the child under the care of another medical specialist? Y / N If so, who? What Specialty?: _____	Phone: _____

Please list any chronic illnesses, disabilities, medical conditions that your child has been diagnosed with:

Illness/Disability: _____ Date: _____

Illness/Disability: _____ Date: _____

Illness/Disability: _____ Date: _____

Medication

Please list all medications your child is currently taking:

Medication:	Dosage:	Treating:

Is your child currently seeing another therapist? Y / N If YES, whom is the child seeing? _____

Has your child ever experienced a psychiatric hospitalization? Y / N. Please describe the circumstances:

Is your child under the care of a psychiatrist? Y / N If YES, psychiatrist name/phone: _____

Has your child ever experienced any type of abuse (physical, sexual, or emotional)? Y / N If YES, please describe:

Has your child ever made a statement of wanting to harm themselves or another? Y / N If YES, please describe:

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Child/Adolescent Intake Form Page 3

Please provide the following information about your child:

Are there any behaviors you child does too often, too much, or at the wrong times that gets the child in trouble? Please Describe:

Are there any behaviors your child fails to do as often as you would like or when you would like? Please Describe:

Please list positive strengths your child possesses (What do you like about your child? What do others like about your child?):

How would you describe your child's self-esteem?

Briefly describe your reason(s) for seeking help at this time:

What goals do you have as your best hope for what therapy can do for you as a parent?

What goals does your child wish to accomplish by going through the therapeutic process? (This may be different from the parent's response)

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Child/Adolescent Intake Form Page 4

Please provide the following information about your child:

Family History

Mother's Name: _____ Father's Name: _____

Occupation?_____ Occupation? _____

Step-Mother: _____ Step-Father: _____

With whom does the child currently live, primarily? _____

Please list members of your child's primary household:

Name	Age	Relationship to child	Grade/Job
Who are your child's significant others NOT living with your child?			
Are child's parents':			
Married	Separated	Divorced	Widowed
Who in the family is your child closest to?			
What are some strengths of your family?			
Is there anything else you think would be important to be known about your child, you, or your family?			

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Parents—This page is for your CHILD to complete to the best of their ability. Thanks for your cooperation!

Name:_____ Today's Date: _____ Nickname you go by: _____

Age:_____ Birthday: _____ Name of School: _____ Grade Level: _____

What are your favorite school subjects? _____

What are your least favorite subjects? _____

What extra-curricular activities or sports do you enjoy? _____

Have you moved around a lot or changed schools? If so, tell me a little about that: _____

_____

Who are some of your closest friends (first names only) : _____

Do you have any pets? What kind? What are their names? _____

What are some things you like about yourself? _____

_____

What are some things you wish were different about yourself? _____

_____

What are some personal goals or things you want to accomplish in the future? _____

_____

Sometimes kids/teens come to counseling because they want to be here. Sometimes they come because adults want them to be here. Tell me about why you are here today: _____

_____

If counseling could help make something different in your life or different in your family, what would YOU want that to be?

_____

_____