



IMPROVing Life Counseling Inc.
Yes, and... your life

Child Client Information/Intake Form

Client Name: _____

Date of Birth: _____ Age: _____ Ethnicity/Cultural Identity: _____

Gender: M F Other Sexuality: _____

Address: _____
(street) (city) (state) (zip)

Employer/School & Current Grade: _____

Home Phone: _____ OK to leave a message? Yes No

Cell Phone: _____ OK to leave a message? Yes No

Work Phone: _____ OK to leave a message? Yes No

Client Email: _____ OK to email you? Yes No

Primary Care Physician: _____

Client Marital Status: Single Married Separated Divorced Other: _____

How did you hear about our practice? _____

PARENT/GUARDIAN INFORMATION (FOR CLIENTS UNDER THE AGE OF 18):

Mother/Guardian Name: _____

Address (if different than above): _____
(street) (city) (state) (zip)



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Phone: (Home) _____ (Cell) _____ (Work) _____

OK to leave a message at the numbers above? Yes No

Email address: _____ OK to email you? Yes No

Mother's Occupation: Position: _____ Employer: _____

Father/Guardian name: _____

Address (if different than above): _____
(street) (city) (state) (zip)

Phone: (Home) _____ (Cell) _____ (Work) _____

OK to leave a message at the numbers above? Yes No

Email address: _____ OK to email you? Yes No

Father's Occupation: Position: _____ Employer: _____

Child currently resides with: Both Parents Mother Father Other _____

Parents' current marital status: Married Separated Divorced Widowed
Other (please specify): _____

If remarried, please provide year of remarriage: Mother: _____ Father: _____

Sibling Name(s) of Minor Client	Age	Resides with:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



CLINICAL INFORMATION:

Please briefly describe your reason for seeking therapy:

Have you/your child ever been in therapy or received any type of counseling before? Yes No
If yes, please list when, where and with whom you received services and the reason?

Are there any safety concerns about the client (please include past or present concerns)? This may include, but is not limited to, aggressive behavior toward self or others or thoughts of self-harm or suicide.

Yes No

If yes, please describe:

Please list any major illnesses and/or hospitalizations if applicable, with approximate dates:

Please list any current medications you/your child is taking (name of medication and dosage, including OTC medication):



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Have you/your child had any substance abuse issues? Yes No

If yes, please describe/provide more detail:

If there is any other additional information that that you would like to share, please include it below:
