



2209 E Market St
 York, PA 17402
 Phone: (717)759-1024

Intake Form (13 years old and younger)

Please complete this form to the best of your knowledge. Please know that all content shared on this intake form will be held confidential and not shared without your consent. If there is anything that you wish to not share, leave those questions blank. If there are any questions that do not pertain to you, please mark that as N/A and move to the next.

Name _____ Date _____

DOB _____ Preferred Name _____

Can a message be left on the voicemail? () yes () no Phone number _____

Address _____

Preferred Pronouns _____ Gender _____

Is there a religion consideration yes () no ()

If yes, please explain _____

Emergency Contact (name & number) _____

How did you find Therapeutic Family Connections? _____

Please list all healthcare providers. Can they be contacted to collaborate care () Yes () No

Name Phone Number Agency

Name	Phone Number	Agency
Case Manager		
Case Worker		
Nutritionist		
Primary Care Physician		
Psychiatrist		
Other		



2209 E Market St
York, PA 17402
Phone: (717)759-1024

Are there any special needs that should be noted? Hearing aid devices, interpreter, mobility assistance, ect.?

Education

School _____ Grade _____

What are the academic strengths? _____

Are there any academic struggles? _____

What kind of education? General Education () 504 plan () IEP ()

If there is a 504 or IEP, what are the accommodations? _____

Describe friendships in school. _____

Learning Style- Auditory, Visual, Read / Write, or Kinesthetic (Doing)? _____

What are your child's strengths outside of school? _____

What does your child enjoy doing? (activities, hobbies, or interests) _____



2209 E Market St
York, PA 17402
Phone: (717)759-1024

Are there any concerns about behavior or truancy at school? If so, please explain _____

Family Information

Parent 1

Name (Parent) _____ Date of Birth _____

Phone Number _____ Lives with Child/ren Yes () No ()

Can a voicemail be left on this phone number? Yes () no ()

Preferred Pronouns _____ Gender _____

Occupation _____ Working Hours _____

Stepparent _____ Date of Birth _____

Lives with child Yes () No () Occupation _____

Parent 2

Name (Parent) _____ Date of Birth _____

Phone Number _____ Lives with Child/ren Yes () No ()

Can a voicemail be left on this phone number? Yes () no ()

Preferred Pronouns _____ Gender _____

Occupation _____ Working Hours _____

Stepparent _____ Date of Birth _____



2209 E Market St
York, PA 17402
Phone: (717)759-1024

Lives with child Yes () No () Occupation _____

Are the biological parents married () divorced (), separated () or deceased ()

Is there a custody order? Yes () no ()

If yes, please explain the custody order? _____

How would you describe the relationship between parents / caregivers? _____

Are parents / caregivers at risk of splitting up? Yes () No () Unsure ()

Please explain _____

Are there any siblings?

Name _____	Age _____	Lives with Child Yes () No ()
------------	-----------	---------------------------------

Name _____	Age _____	Lives with Child Yes () No ()
------------	-----------	---------------------------------

Name _____	Age _____	Lives with Child Yes () No ()
------------	-----------	---------------------------------

Name _____	Age _____	Lives with Child Yes () No ()
------------	-----------	---------------------------------

Name _____	Age _____	Lives with Child Yes () No ()
------------	-----------	---------------------------------

Any additional household members? _____

Presenting Problem

What are the areas of concern? Why are you seeking therapy? _____



2209 E Market St
 York, PA 17402
 Phone: (717)759-1024

What would your treatment plan goals be? What would you hope to accomplish? In what areas would you like to improve, learn, and develop? _____

What are the concerning behaviors that bring you to therapy _____

Check any of the following symptoms that are concerning or relevant

ADHD		Irritability	
Aggression		Isolates	
Aggressiveness		Learning Disorder	
Anger Outbursts		Mood Swings	
Animal Cruelty		Moody	
Anxiousness / Anxiety		More than 3 hrs of Electronics A Day	
Bed Wetting		Paranoia	
Bingeing		Plays Well with Others	
Clingy		Plays with Fire	
Defiance		Poor Sleep	
Delusions		Prefers independent play	
Depression		Purging	
Destroys / Damages Property		Racing Thoughts	
Disordered Eating		Repetition with Behaviors	
Eating Difficulties		Repetition with Words	



2209 E Market St
 York, PA 17402
 Phone: (717)759-1024

Please explain any recent changes or transitions. _____

Substance Use

Has your child ever used any of the following drugs, to your knowledge?

Substance Type	Yes	No	Current Use (0- 6 months)	Amount / Frequency	Yes	No	Past Use (6+ months)	Amount/ Frequency
Alcohol								
Caffeine								
Crack/ Cocaine								
Ecstasy								
Heroin								
Inhalants								
Marijuana								
Methamphetamines								
Nicotine Vape								
Painkillers- Not prescribed								
PCP/LSD								
Prescription Pills								
Sleeping Pills								
Stimulants								
Steroids								
Tobacco								



2209 E Market St
York, PA 17402
Phone: (717)759-1024

Please explain the above _____

Did your child receive any treatment for substance use? If so, from where, when, and what was the outcome?

Do you still have concerns for substance use? Yes () No ()

Family History

Has anyone in your family ever been diagnosed and treated for any of the following? If so, who and when?

Alcohol abuse _____

Anxiety _____

Bipolar disorder _____

Depression _____

Intellectual disabilities _____

Eating Disorders _____

Panic Attacks _____

Personality Disorder _____

Post-Traumatic Stress Disorder _____

Substance abuse _____

Child Developmental History

Was there any emotional distress experienced while birthmother was pregnant? If so, please explain.



2209 E Market St
York, PA 17402
Phone: (717)759-1024

Did birthmother receive medical care throughout pregnancy Yes () No ()

Please list any complications at birth or infancy. _____

Approximate milestone age for walking _____ talking _____ toilet training _____

Have there been any concerns about bed wetting and toilet training? Is so, please explain _____

Was the client diagnosed with exposure to alcohol or drug use while in utero? Yes () No ()

Was the child ever in speech therapy? Yes () No ()

Please explain any other therapies utilized for developmental concerns. (Occupational, feeding, etc.) _____

Are there or have there been any concerns with vision? Please explain if yes. _____

Are there or have there ever been concerns with hearing? Please explain if yes. _____

Mental Health History

Please explain any mental health diagnosis. _____



2209 E Market St
 York, PA 17402
 Phone: (717)759-1024

Who gave the diagnosis and when? _____

Please list previous mental health therapy experiences. (name, date, & outcome) _____

Did you find previous treatment to be helpful? Yes ____ No ____ Why? _____

Was your child compliant with previous treatment? Please explain _____

Additional space for any other symptoms or concerns not listed _____

Please list all prescribed, over the counter, and homeopathic medications that you are currently taking.

Medication name	Dose	Dosage Instructions	Prescribed By	What is the medication prescribed for?



2209 E Market St
 York, PA 17402
 Phone: (717)759-1024

--	--	--	--	--

Please indicate any current or past treatment that you have been involved in.

Yes	No	Treatment	When	Were	Outcome
		Outpatient Therapy			
		Partial Hospitalization			
		Psychiatric Hospitalization			
		Support Groups			

Additional space for other treatments that are not listed _____

Any **past** or **current** thoughts/plans/acts/ideation or intention of suicide? Please explain or write N/A if it does not apply. _____

Any **past** or **current** thoughts/plans/acts/ideation or intention of homicide? Please explain or write N/A if it does not apply. _____

Any **past** or **current** thoughts/plans/acts/ideation or intention of self-harm? Please explain or write N/A if it does not apply. _____

Medical Health History

Are there any allergies? If so, please explain. _____



2209 E Market St
York, PA 17402
Phone: (717)759-1024

Is there any medical diagnosis that the therapist should be made aware of? If so, please explain. _____

What opportunity does your child have for physical activity? _____

What opportunities does your child have to play outside? _____

How much time on technology devices is your child exposed to daily? _____

Trauma

Did your child ever experience or witness domestic violence? If so, please explain. _____

Has your child ever experienced trauma? (sexual abuse, physical abuse, neglect, witness abuse, violence, or someone die, etc.) If so, please explain. _____



2209 E Market St
York, PA 17402
Phone: (717)759-1024

What was your child's response to the trauma? _____

Did your child receive treatment for the trauma? If so, when, with whom, and outcome? _____

Any additional information that would be helpful for your therapist to know? _____

Do you foresee any barriers to treatment? If so, what? _____

**By signing below, you are attesting that the above information is completed to the best of your ability.
Your signature also consents to treatment for adults and child/ren in the family.**

Signature _____ Date _____

Guardian Signature (If under 18) _____ Date _____

Therapist Signature _____ Date _____