

CHILD/ADOLESCENT CLIENT INTAKE FORM

For therapy with Jennifer A. Watts, Ph.D., LMFT
25-B Lenox Pointe, N.E., Atlanta, GA 30324

Date _____

Referred by (if internet, which site/s?) _____

If a personal/professional referral, may I thank the person? Yes No

CHILD/ADOLESCENT GENERAL INFORMATION – please print

Last name _____ First name _____ MI _____

Street Address _____
(street) (city) (state & zip)

Cell phone _____ preferred ok to leave message?

Home phone _____

Email address _____

Birth date ____/____/____ Age _____

School attending _____ Grade _____

FAMILY INFORMATION

Child’s parents are: single married/partnered divorced (date: ____/____/____) widowed

Parent 1: Name _____ Birth date ____/____/____ Age: _____

preferred ok to leave message?

Home phone _____

Cell phone _____

Work phone _____

Email address _____

Parent 2: Name _____ Birth date ____/____/____ Age: _____

preferred ok to leave message?

Home phone _____

Cell phone _____

Work phone _____

Email address _____

Others living in child’s home (Names/Relationship/Age): _____

Legal custodian (if applicable) _____

In case of emergency, contact _____

Please Note: I do have a 24-hour cancellation policy.
Appointments not cancelled with at least 24 hours notice will be charged at the full rate.

Relationship _____ Emergency phone _____

COUNSELING CONCERNS

Why are you seeking help for your child now? _____

What would you like to see happen as a result of psychotherapy? _____

MEDICAL AND PSYCHOLOGICAL HISTORY

Child's physician's name and phone number: _____

Date of last physical: _____

List physical illnesses or symptoms: _____

List current medications: _____

Has your child received psychotherapy or counseling in the past? No Yes

If so, when and with whom? _____

Child's psychiatrist's name and phone number: _____

List current medications: _____

Has any member of your family received help for drug or alcohol dependency?

No Yes Who? _____ When? _____ Where? _____

Have you or any member of your family been hospitalized for mental/emotional/psychiatric reasons?

No Yes Who? _____ When? _____ Where? _____

OTHER

On the other side, please provide any other information you think will be necessary or helpful.

Please Note: I do have a 24-hour cancellation policy.
Appointments not cancelled with at least 24 hours notice will be charged at the full rate.