ACTSolutions

923 South Church Street, Grapevine Tx 76051 817.707.3329

CHILD/ADOLESCENT INTAKE

Child/Adolescent's name: _____ Age: _____ DOB: _____
School: _____ Grade: _____
Teacher: _____ Counselor: _____

Parent(s): _____
Home phone: _____ Work phone: _____
Address: _____
Street Apt. # City/State/Zip

If parents are divorced, please list non-custodial or joint-custody parent:_____ Home phone: _____
Work phone: _____ Address: _____
Stepparent: _____

Years divorced: _____ date of divorce: _____
Age of child at divorce: _____
Please list siblings (Clarify if living in home by 'IN' beside name):
_____ Age: _____ DOB: _____ Gender: _____
_____ Age: _____ DOB: _____ Gender: _____
_____ Age: _____ DOB: _____ Gender: _____
_____ Age: _____ DOB: _____ Gender: _____

Please list step-siblings (Clarify if living in home by 'IN' beside name):
_____ Age: _____ DOB: _____ Gender: _____
_____ Age: _____ DOB: _____ Gender: _____
_____ Age: _____ DOB: _____ Gender: _____

Reason for seeking therapy for your child/adolescent:

I acknowledge that I, _____, am legal guardian of _____. This is to certify that I give permission to Deborah M. Wade, MA, LMFT, LPC, of ACTSolutions to provide counseling to my child/adolescent. Treatment may include any of the following: play therapy, individual therapy and/or family therapy. I understand that it is my legal right to gain access to my child/adolescent's records. I also realize that at times the nature and content of such services may need to remain confidential.

_____ _____
Signature of parent or guardian Date