Child Counseling Intake Form

Personal Information:

Child's Full Name: ____

Date of Birth: ____

Age: _______ Gender: ☐ Male ☐ Female ☐ Other

Parent/Guardian Name(s): _____________________________________

Address: ____

Phone Number: ____

Email Address: ____

Emergency Contact:

Name: ____

Relationship to Child: ____

Phone Number: ____

Reason for Counseling:

☐ **Behavioral Concerns**

☐ **Emotional Challenges**

☐ **Social Difficulties**

☐ **Academic Struggles**

☐ **Other: ____**

Child's Medical History:

Allergies: ____

Chronic Conditions: ____

Medications: ____

Past Counseling History: ☐ Yes ☐ No

Session Goals:

1. ____

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2. ______________________________

3. ______________________________

Behavioral Observations Table:

Behavior/Issue	Frequency (Daily/Weekly)	Intensity (Mild/Moderate/Severe)	Notes

Parent/Guardian Consent:

☐ **I consent to my child receiving counseling services.**

Signatures:

Parent/Guardian: ______________________________ Date: ________________

Counselor: ___________________________________ Date: ________________

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