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**Client Information**  
**(Children and Adolescents)**

1. What are the current symptoms that the client is experiencing?

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2. How long have the symptoms been occurring?

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3. Have there been any major changes in school or at home lately? Yes No If yes please explain below

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4. Is the client currently receiving any treatment? Yes No If yes please answer below

Where is the current place of treatment? \_\_\_\_\_

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5. Has the client received any previous treatment? Yes No If yes please answer below

What were the reason(s) for the treatment? \_\_\_\_\_

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6. Has client currently or ever been prescribed any medication? Yes No If yes please explain below

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7. Is the client currently experiencing any thoughts of self harm? Yes No

8. Harm to others? Yes No

9. Is the client currently exhibiting any of the following symptoms?

Fatigue	Yes	No	Hearing Voices	Yes	No	Sexual Acting Out	Yes	No
Lying	Yes	No	Bed Wetting	Yes	No	Stomach Problems	Yes	No
Worries	Yes	No	Poor Appetite	Yes	No	Difficulty Sleeping	Yes	No
Anxiety	Yes	No	Change in Mood	Yes	No	Poor Concentration	Yes	No
Hyperactivity	Yes	No	“Sleep Walking”	Yes	No	Bowel Problems	Yes	No
Stealing	Yes	No	Unusual Fears	Yes	No	Nightmares/Bad Dreams	Yes	No
						Frequent Anger Outbursts	Yes	No

If you answered yes to any of the previous questions please give more details in the space below.

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10. Please list below any other concerns you have regarding your child that was not covered in the intake form?

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Consent for the treatment of children and adolescents:

I/We consent that \_\_\_\_\_ may be treated as a client by Christy Shea.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Print Name

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Signature

Date