Hope's Road Counseling Services
Parent Intake Form

PERSONAL Information:

Your Name ___________________________________Birth Date ________

Address____

____

Home phone _________________ Cell_________________

Work phone____________

Your child was referred by:_____________________________________

Employer ____

Position ___________________

Education (last year completed or degree)

____

Current Marital Status:

_____ Never married _____Engaged _____Married

_____Separated _____Divorced _____Widowed

In case of emergency contact___________________ Relationship__________

Your childs name_____________________________

Birthdate___________________

School____Grade_____

Marriage and Family Information:

Spouse ___________________________ Birth Date ________ Date of

Marriage __________

Employer____

Occupation ______________________

Education (last year completed or degree)

____

List your children:

Name ______________________ M/F Age: ___ Living __ Deceased_____

Name ______________________ M/F Age: ___ Living __ Deceased_____

Name ______________________ M/F Age: ___ Living ___ Deceased_____

Name ______________________ M/F Age: ___ Living ___ Deceased____

If you have been married before or had children from earlier relationships, please fill out the following information:

<u>Information about you:</u>

Former spouse's first name _____________________

Reason for separation: Death ___ Divorce ___

Married from Month/Yr. __________ To Month/Yr. __________

Children:

Name ______________________ M/F Age: ___ Living with: ______

Name ______________________ M/F Age: ___ Living with: ______

Name ______________________ M/F Age: ___ Living with: ______

<u>Information about your spouse:</u>

Former spouse's first name _____________________

Reason for separation: Death ___ Divorce ___

Married from Month/Yr. __________ To Month/Yr. __________

Children:

Name ______________________ M/F Age: ___ Living with: ______

Name ______________________ M/F Age: ___ Living with: ______

Name ______________________ M/F Age: ___ Living with: ______

Your Child's Health:

(please answer accordingly for the child who will be receiving counseling)

Is your child healthy? ______________Does your child have any chronic illnesses (for example, asthma or diabetes) _______

If yes, what have they been diagnosed with?

____

Current medications

____

Name of physician

_______________________________________Phone__________________

Your Child's Emotions:

Has your child ever had a **severe** emotional upset? ________

If yes, please explain (including date of upset)

____

____

Has your child ever seen a psychiatrist or counselor? _______

If yes, please explain (including dates of service)

____

____

Name of pervious counselor_______________________________________

How would you currently describe your child?

____

____

What has led you to seek counseling for your child?

____

____

What have you already tried to do about this?

____

____

What are your expectations for counseling for your child?

____

____