THE THERAPY PLACE OF LA CROSSE, LLC

CHILD/ADOLESCENT INTAKE FORM

Name: _____ **Age:** _____ **DOB:** _____

School: _____ **Grade/Teacher:** _____

Referred by: _____

Primary Care Physician/Clinic: _____

Current Medications: _____

Please circle any of the following that apply to you:

Family problems	Problems with appetite
Friend Problems	Weight Loss or Gain
Problems at home	Problems at school
Feeling sad/depressed	Feeling worried
Other people concerned about your eating	Drug/alcohol problems
Thoughts of ending your life	Thoughts of hurting yourself or others
Feelings of hopelessness	Learning problem
Problems sleeping	Something bad or scary happened

Some of my favorite things to do are:

_____

_____

_____

_____

Some things I am good at are:

_____

_____

_____

Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____