

INTAKE FORM

For Parent

KIM OLSON, MFT

INDIVIDUAL AND FAMILY THERAPY

LICENSE# MFT 35572

This information is requested so that I may be most helpful to your family. Please feel free to talk with me about any questions or concerns.

Your Name	Date	
Your Child's Name	Child's Birthdate	
Address		
Home Phone	Work Phone/Cell	
Insurance (if any)	Insured's Name and Date of Birth	
Please describe your reason(s) for seeking psychotherapy for your child now		
Who referred you?		
Has your child ever been in psychotherapy before? If yes, with whom and for how long?		
Please describe your reasons for seeking psychotherapy for your child then		
Please list who presently lives in your home, and their age and relationship to you		
Name	Age	Relationship

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PERTINENT HISTORY

Please describe any significant changes in your family recently (e.g. separation, divorce, deaths, changes in jobs, schools, friends, homes, etc.)

Does your child get along with his/her brothers and/or sisters (if applicable)?

Does your child get along with his/her friends/peers?

Is your child currently dating?

How does your child get along with his/her parents?

Has your child ever experienced any type of traumatic event (i.e. physical, sexual, or emotional abuse, rape, divorce)? If yes, please describe

Have you noticed any changes in your child's eating habits? If yes, please describe

Have you noticed any changes in your child's mood? If yes, please describe

Has your child ever verbalized a desire not to live anymore? If yes, please describe

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Does your child use:

Laxatives

Diet pills

Self-induced vomiting

Alcohol

Cigarettes

Drugs

SCHOOL/HISTORY

What school does your child currently attend?

Which grade is your child currently in?

What are your child's grades in school?

Does your child experience any struggles academically?

Does your child participate in any hobbies/extracurricular activities?

PERTINENT MEDICAL HISTORY

Who is your child's primary care physician?

Please provide approximate date of last visit

Does your child have any medical problems that he/she is currently experiencing? If yes, please describe

Is your child presently taking any medications? If yes, please state the name and dosage of medications

What is your child's current weight?

What is your child's current height?

Does your child talk about dieting or trying to lose weight?

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FOR GIRLS

Has your daughter started her period?

If yes, is it regular?

If no, has it stopped?

Please describe any significant illness your child has experienced

Does your child have a family history of (please check all that apply)?

Depression

Alcohol/Drug Problem

Overweight

Underweight

Anxiety/Panic Attacks

Psychiatric Hospitalizations

Is there anything I didn't ask that you would like me to know?