Holly Pedersen PhD MFT
Individual, Couple and Family Psychotherapy
www.hollypedersenMFT.com

Intake Form: Child & Family Therapy

Parent's Name:_____**Birth Date:** _____

Address: _____

City: _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____

E-mail Address: _____

Parent's Name:_____**Birth Date:** _____

Address (or indicate if same as above): _____

City: _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____

E-mail Address: _____

Child's Name: _____ **Birth Date:** _____

School: _____**Grade:**_____

Pediatrician: _____

Medications:_____

Allergies:_____

Other children and family members in the home (please give names and ages):

_____

_____

Please check:
Married_____ Separated_____Divorced_____ Other (describe) :_____

If separated or divorced:

Is there a court ordered custody plan? _____

If Yes:
Joint legal custody_____ or Sole legal custody held by:_____

Please describe physical custody/visitation arrangement_____

_____

Prior mental health treatment:
Type:_____; Clinician:_____Dates:_____

Type:_____; Clinician:_____Dates:_____

Description of the problem:

_____

_____

_____

How long has the problem been occurring?

_____

Your goals and desired outcomes for treatment:

_____

_____

In case of emergency, contact: _____

Name

_____

Address

_____

Phone Number **Relationship**

Who referred you/ how did you find me:

_____

Form Completed by: _____

Date:_____