

**ERIN LIEBMAN**

School Psychologist, Reading Specialist, Licensed Clinical Professional Counselor

# Intake Form (Minor Child)

---

Please circle the symptoms which are applicable, and indicate the duration which your child experienced them:

Symptom	Duration	Symptom	Duration
Sadness		Self-control Problems	
Anxiety/Worry		Attention/Focus Problems	
Sleep Changes		Bullying	
Weight Changes		Suicidal Thoughts	
Confusing/Racing Thoughts		Grief/Loss	
Frequent Crying		Work Problems	
Isolation/Loneliness		Family Problems	
Appetite Changes		Relationship Problems	
Restlessness		Health Problems	
Difficulty Concentrating		Self-Esteem Issues	
Moodiness		School/Learning Problems	
Peer Relationship Problems		(Other)	

If Other, please explain:

Has your family ever participated in therapy? Y N

If yes, please describe with whom, and for how long? Was it helpful?

Please list your child's past and current medications:

Medication	Year	Doctor	Duration

Has your child ever been hospitalized for psychiatric reasons? Y N

If yes, please describe.

**ERIN LIEBMAN**

School Psychologist, Reading Specialist, Licensed Clinical Professional Counselor

**Please describe any medical problems, concerns, or hospitalizations (past and present) that have impacted your child.**

**Please list any medical and/or mental health problems that run in your family**

<b>Medical/Mental Health Problem</b>	<b>Family Member</b>

**Please explain your reason(s) for beginning therapy:**

\_\_\_\_\_  
**PARENT/GUARDIAN SIGNATURE**

\_\_\_\_\_  
**DATE**