Sonja Glad, MA, DPsS, LCPC

Licensed Clinical Professional Counselor

901 S. Second St. Suite 100

Springfield, IL 62704

(217) 720-5981

Date:_____

Child Intake Information

Child's Full Name:_____ SS#:_____

Address:_____ City:_____ State:___ Zip:_____

Date of Birth:_____Gender:_____Name of School:_____Grade:_____

Issues At School:_____

_____

Doctor's Name and Phone #:_____

Date of Last Physical:_____

Physical Health Issues:_____

Medications:_____

Allergies:_____

Serious Accidents, Illness, Surgeries or Birth Trauma:_____

_____

Previous Therapy (name and dates) :_____

Exercise/Sports:_____

Hobbies:_____

Mother's Name:_____Date of Birth:_____

Address:_____ City:_____ State:_____Zip:_____

Primary Phone #:_____ Work #:_____ Other #:_____

Occupation:_____ Employer:_____

Father's Name:_____Date of Birth:_____

Address:_____ City:_____ State:_____Zip:_____

Primary Phone #:_____ Work #:_____ Other #:_____

Occupation:_____ Employer:_____

Are Parents: Living Together/Married/Separated/Divorced:_____

Current Custody/Living Arrangements:_____

Sibling's Names	Bio, Step,Adopted	Gender	Age	With Whom Do They Reside?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please List The Issues You Would Like To Have Addressed In Therapy:_____

_____

_____