



THE PRIVATE PRACTICES OF

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Child/Adolescent Intake Form

Name: _____ Date: _____
First Initial Last Nick

Referred by whom: _____ Phone: _____

Age: _____ DOB: _____ Grade: _____ School: _____

Address: _____ City: _____ Zip: _____

Home #: _____ Home Email: _____

Mother _____ Cell # _____ Stepfather _____ Cell # _____

Mother's Address (If different than child): _____ City: _____ Zip: _____

Mother's preferred email: _____ Home # (if different than child): _____

Father _____ Cell # _____ Stepmother _____ Cell # _____

Father's Address (If different than child): _____ City: _____ Zip: _____

Father's preferred email: _____ Home # (if different than child): _____

Custody arrangements: _____

Sibling(s) (including ages): _____

Reason for seeking services/stressors/Goals/Expectations: _____

Has the child has prior therapy? Yes ___ No ___ With whom (dates/issues): _____

Physician: _____ Phone #: _____

Assessment of Current Health: Good ___ Fair ___ Poor ___ Allergies: _____

Health Issues: _____

<u>Current Medication(s)</u>	<u>Dosages</u>	<u>Prescribing Physician</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Hospitalizations/In-Patient facilities (date/reason): _____