Nurturing Village, LLC
Family Counseling & Coaching

7115 Virginia Road, Suite 108, Crystal Lake, IL 60014
(815) 893-9484
www.nurturingvillage.com

New Family Intake Form

Basic Information:

Client's complete name: _____Date: _____

Age:_____ Birth date:_____

Parent/guardian/caretaker's name(s)_____

Address:_____

City: _____ State:_____ Zip Code:_____

Phone: Home_____Cell_____ Work:_____

Referred by:_____

Contact information:

I can best be reached by: ___ phone call (cell___ home___ work ___)

___ text (please note that this is not a secure form of communication and Nurturing Village will never leave any identifying information in a text message)

___ email (please note that this is not a secure form of communication and Nurturing Village will never leave any identifying information in an email)

Email address: _____

Do you give permission to leave a message on a voicemail? ___ yes ___ no

Does your child have any allergies (food or otherwise?)

_____

Person to alert in the event of medical emergency: _____

Relationship to client:_____ Phone:_____

Primary Care Doctor:_____

Address: _____ _Phone:_____

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Psychiatrist: _____

Medications: _____

Insurance Information:

Policy Holder (Member) Name:_____ Relationship to Client:_____
Policy Holder (Member D.O.B.)_____
Insurance Company: _____ Insurance Phone #:_____
Member ID #:_____ Group Plan #:_____

Family Information:

Please tell us about all of the people living in the home:

Name of household member	Relationship to child	Age	One word description of person's relationship with child

Please feel free to continue listing on back of page.

Please describe any significant current or past medical problems for your child, including any complications at birth:

_____

_____

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Has your child had previous psychiatric care or counseling? Yes No

If yes, please give the name of the clinician(s), the months you saw them (e.g., Nov 06 - Feb 07), and the nature of the difficulty at the time.

Have your child ever been hospitalized for a psychological difficulty? Yes No

If yes, please give the dates and the nature of the difficulty at the time:

What are some strengths that you see in your child? What makes your child special?

In your own words, what is the nature of the concern that you wish to address in therapy? Feel free to describe this in as much or as little detail as you wish. Use additional paper if you like.

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Additionally, please check if you have concerns about your child's:

____ sleep patterns	____ behavior patterns	____ phobias / fears
____ diet / eating habits	____ self care skills	____ anxiety
____ energy level	____ organization / planning skills	____ other:
____ sensory regulation	____ school attendance	
____ emotionality / moodiness	____ other school concerns	
____ social skills	____ attention / impulsivity	

Please check if your child currently has an: ____ IEP ____ 504 Plan

Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal, but please make at least an initial effort. You can discuss this further with your therapist. Feel free to list more than one goal if you wish.

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Is there anything else that you would like us to know?

_____

_____

_____

Client Guardian's Signature:_____**Date:**_____