Winning At Home

Confidential Child Intake Form

Today's Date: _____

Child's Name: _____ **Date of Birth:** _____ **Sex: M__ F__** **Living With:** _____ **School:** _____ **Grade:** _____ **Home Phone:** _____ **Cell Phone:** _____ **Email:** _____ **Social Security #:** _____	**Mother's Name:** _____ **Date of Birth:** _____ **Address:** _____ **City:** _____ **ZIP:** _____ **Employed by:** _____ **Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____ **Email:** _____ **Social Security #:** _____	**Father's Name:** _____ **Date of Birth:** _____ **Address:** _____ **City:** _____ **ZIP:** _____ **Employed by:** _____ **Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____ **Email:** _____ **Social Security #:** _____
Religious Affiliation: _____	**Marital Status: Single:** _____ **Married:** _____ **Separated:** _____ **Divorced:** _____ **Widowed:** _____ **Living Together:** _____	

OTHER CHILDREN:

NAME	AGE	SCHOOL/GRADE	BIOLOGICAL OR ADOPTED

Name of anyone else living in the home: _____

Child's physician's name: _____ Date of their last physical: _____

Is your child currently being treated for any medical conditions? Y N If yes, please explain: _____

_____

Is your child currently taking any medications? Y N If yes, please list: _____

_____

_____

Please list your child's allergies: _____

Has your child received previous counseling? Y N If yes, by whom?_____ Date/Year?_____

Please briefly state why they are currently seeking counseling:_____

_____

Referred By: _____ Address:_____

*I would like to send a note of appreciation to the person who referred you for supporting our ministry. Please sign below for your permission.

Name: _____ Date: _____

I authorize Winning At Home Family Wellness Center to use the email and mobile number to send changes and/or confirmations to my or your child's appointment schedule.

Signed _____