WINNING AT HOME

P 616.772.1733
F 616.879.0072
winningathome.com

Child Intake Form

CONFIDENTIAL

CHILD'S INFORMATION

Name:
Date of Birth: **Sex:** M F
Living With:
School: **Grade:**
Home Phone:
Cell Phone:
Email:
Social Security #:
Religious Affiliation:

MOTHER'S INFORMATION

Name:
Date of Birth:
Address:
City: **ZIP:**
Home Phone:
Cell Phone:
Email:
Social Security #:
Employer:
Work Phone:
Religious Affiliation:
Marital Status: Single Married Separated Divorced Widowed Living Together

FATHER'S INFORMATION

Name:
Date of Birth:
Address:
City: **ZIP:**
Home Phone:
Cell Phone:
Email:
Social Security #:
Employer:
Work Phone:
Religious Affiliation:
Marital Status: Single Married Separated Divorced Widowed Living Together

OTHER CHILDREN

Name	Age	School/Grade	Biological/Adopted
1.			
2.			
3.			

Name of anyone else living in the home:

Form continues on back side

MEDICAL HISTORY

Child's physician's name: **Date of last physical:**

Is your child currently being treated for any medical conditions? YES NO

If yes, please explain:

Is your child currently taking any medications? YES NO

If yes, please list:

Please list your child's allergies:

Has your child received previous counseling? YES NO

If yes, by whom? **Date/Year:**

Please briefly state why they are currently seeking counseling:

REFERRAL INFORMATION

Referred by: **Address:**

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

Signed: **Date:**

COMMUNICATION AUTHORIZATION

I authorize Winning At Home Family Wellness Center to use the email and mobile number listed above to send changes and/or confirmations to my child's appointment schedule via text message or voicemail.

Signed: **Date:**

EMERGENCY CONTACT INFORMATION

Name: **Phone Number:**

Relationship to Client: