Christy Shea, M.A., LMFT
1008 Fifth St.
Santa Rosa, CA. 95404
(707) 328-7991
Christy@sheacounseling.com
www.sheacounseling.com

Client Information
(Children and Adolescents**)**

1. What are the current symptoms that the client is experiencing?

_____

_____

_____

2. How long have the symptoms been occurring?

_____

_____

3. Have there been any major changes in school or at home lately? Yes No If yes please explain below

_____

_____

_____

4. Is the client currently receiving any treatment? Yes No If yes please answer below

Where is the current place of treatment? _____

_____

5. Has the client received any previous treatment? Yes No If yes please answer below

What were the reason(s) for the treatment? _____

_____

_____

6. Has client currently or ever been prescribed any medication? Yes No If yes please explain below

_____

_____

7. Is the client currently experiencing any thoughts of self harm? Yes No

8. Harm to others? Yes No

9. Is the client currently exhibiting any of the following symptoms?

Fatigue	Yes	No	Hearing Voices	Yes	No	Sexual Acting Out	Yes	No
Lying	Yes	No	Bed Wetting	Yes	No	Stomach Problems	Yes	No
Worries	Yes	No	Poor Appetite	Yes	No	Difficulty Sleeping	Yes	No
Anxiety	Yes	No	Change in Mood	Yes	No	Poor Concentration	Yes	No
Hyperactivity	Yes	No	"Sleep Walking"	Yes	No	Bowel Problems	Yes	No
Stealing	Yes	No	Unusual Fears	Yes	No	Nightmares/Bad Dreams	Yes	No
						Frequent Anger Outbursts	Yes	No

If you answered yes to any of the previous questions please give more details in the space below.

_____

_____

_____

_____

10. Please list below any other concerns you have regarding your child that was not covered in the intake form?

_____

_____

_____

_____

_____

_____

Consent for the treatment of children and adolescents:

I/We consent that _____ may be treated as a client by Christy Shea.

_____ _____

Print Name Signature Date

_____	_____	
Print Name	Signature	Date