



Trinity Christian Counseling
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Clinton Township, MI 48035
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www.trinityct.org/counseling

CHILD INTAKE FORM

Date_____

Child's Information

Child's Name_____ Birthdate_____ Age_____

Address_____

Grade level_____

Mother's Information

Mother's name_____ Birthdate_____

Address_____

Home phone_____ Cell phone_____

Okay to leave detailed message ☐ Y ☐ N

Mothers marital status ☐ Married ☐ Divorced ☐ Engaged ☐ Widowed ☐ Separated

Mother's religious affiliation_____

Mother's email_____

Mother's employer_____

Father's Information

Father's name_____ Birthdate_____

Address_____

Home phone_____ Cell_____

Okay to leave detailed message ☐ Y ☐ N

Father's marital status ☐ Married ☐ Divorced ☐ Engaged ☐ Widowed ☐ Separated

Father's religious affiliation _____

Father's email _____

Father's employer _____

Emergency contact

Name _____ Relationship _____

Phone Number _____ Email _____

Family Information

Who currently resides in the home? Please include any half or step brothers and sisters, grandparents or any others.

Name	Age	Relationship

Name of child's PCP _____ Phone number _____

Date of last well child exam _____ Does your child exercise regularly? ☐ Yes ☐ No

What type of exercise? _____

Does your child have any chronic medical conditions?

List any medications including over the counter and supplements.

Does your child smoke? ☐ Cigarettes ☐ Marijuana ☐ Chew Tobacco ☐ Vape

How much per day? _____

Does your child drink alcohol ☐ Y ☐ N How much _____ How often _____

Has your child had any previous trauma? (physical, sexual, emotional) ☐ Y ☐ N

Please explain:

How does your child handle stress?

Please check any of the following your child has gone through in the past 12 months and briefly explain

Death of a parent ☐ Y ☐ N _____

Divorce of parents ☐ Y ☐ N _____

Separation of parents ☐ Y ☐ N _____

Remarriage of a parent ☐ Y ☐ N _____

Death of a family member ☐ Y ☐ N _____

Personal injury or illness ☐ Y ☐ N _____

Sexual abuse ☐ Y ☐ N _____

Addition to family ☐ Y ☐ N _____

Sibling leaving home ☐ Y ☐ N _____

Financial difficulties for parents ☐ Y ☐ N _____

Loss of home ☐ Y ☐ N _____

Outstanding personal achievement ☐ Y ☐ N _____

Parent change in job or work hours ☐ Y ☐ N _____

Imprisonment ☐ Y ☐ N _____

Minor violation of the law ☐ Y ☐ N _____

Change in residence or school ☐ Y ☐ N _____

Change in social activities or recreational activities ☐ Y ☐ N _____

Change in eating or sleeping ☐ Y ☐ N _____

Revision of personal habits ☐ Y ☐ N _____

Please list any other changes you may have noticed that may help your therapist:

Insurance Information

Insurance carrier _____

Subscribers name _____ Date of birth _____

Contract number _____ Group number _____

Signature _____

I _____ hereby understand that if my insurance will not cover my sessions with any provider from Trinity Christian Counseling that I will be responsible for any payment in full at time of session.

I _____ agree that I have answered the above statements to the best of my knowledge.

Signature _____ Date _____

Thank you,

Trinity Christian Counseling
David E. Brown, L.P.C. N.C.C.
Zhela Bennett, L.P.C.
Amy Prosch, L.M.S.W.

Kristin Hardy, L.P.C. N.C.C.
Dan Burke, L.L.P.