

**Stephanie Montague, Ph.D.**  
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**CHILD CLIENT INTAKE FORM**

**Child Information**

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Parent Information**

Parent's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

**Please list all members of household**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Age: \_\_\_\_\_

**Medical History**

Primary Physician: \_\_\_\_\_

Please list any significant health problems:

\_\_\_\_\_  
\_\_\_\_\_

Please list any medications and who prescribes them:

\_\_\_\_\_  
\_\_\_\_\_

Has child had any previous therapy? If so, when and with whom?

\_\_\_\_\_  
\_\_\_\_\_

What problems is child experiencing? Please be as specific as possible.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I give Dr. Montague permission to leave messages via: \_\_\_text \_\_\_email \_\_\_voicemail

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

How were you referred to Dr. Montague? \_\_\_\_\_

\_\_\_\_\_

May I send a thank-you note to the referrer?    yes    no