Child Play Therapy Intake Form

Child Information

Child's Full Name

Date of Birth

Age

Gender

Address

Parent/Guardian Information

Parent/Guardian Name

Relationship to Child

Contact Number

Email Address

Referral Information

Who referred you?

Reason for referral/concerns

Developmental & Medical History

Significant medical conditions

Current medications

Allergies

Family Information

Family members (list names and relationships)

Significant family events or stressors

Presenting Concerns

Please describe current concerns or issues for your child

When did these concerns begin?

Other professionals involved (e.g. doctors, teachers, therapists)

Goals for Therapy

What would you like your child to gain from play therapy?