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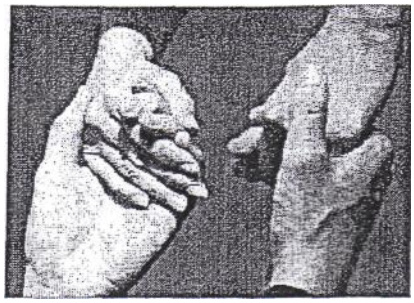

INFORMATION INTAKE FORM (MINOR)

CLIENT INFORMATION

Today's Date: _____/_____/_____

Child's Name: _____

Address: _____

City: _____ Zip:_____

Phone (Home) _____ Phone (Cell) _____

Child's phone: _____ Other: _____

Parent's E-mail:_____

Child's Date of Birth: _____/_____/____ Age:_____

School Attending: _____

Current grade level: _____

PARENTS AND SIBLINGS

Do you have other children? Yes No

If yes, please list them below and designate step-children as ("Step").

1._____ Age_____

2._____ Age_____

3._____ Age_____

4._____ Age_____

5._____ Age_____

Child's current household living arrangements

_____Natural Parents _____Father only

_____Adoptive Parents _____Mother only

_____Natural father and stepmother _____Relatives

_____Natural mother and stepfather

_____Foster family

MEDICAL AND PERSONAL

Name and Phone of Family Physician: _____
_____
_____

Please rate your health: Excellent Good Poor

Date of last physical: _____/_____/_____

Allergies:_____
_____

Medications:_____
_____
_____

Have you had any counseling before? Yes No

Counseling/Therapist Names: _____
_____

Dates: _____ _____

Does your child have an addiction? ___Yes ____ No ____Uncertain

Has your child ever attempted suicide: _____ (if yes, when, method, result) _____
_____

Has your child ever been hospitalized for psychological problems?
If yes, why, where, when, length of time, and admitted by whom?
_____
_____
_____
_____
_____

Has your child ever been arrested: _____Yes _____No

Has your child experienced any previous trauma? (Physical, emotional, sexual abuse, abortion, etc.)_____Yes _____No _____Uncertain

BASIC INFORMATION

Briefly answer the following questions

What concerns have caused you to seek counseling for your child at this time?

_____
_____
_____

When did the problem(s) begin? _____
_____

What has previously been done to try and resolve the problem(s)?
What was the outcome? _____
_____

Please check those issues that concern you (check all that apply):

	Anxiety		Relational concerns		Alcohol concerns
	Depression		Sexual concerns		Drug concerns
	Anger		Sexual assault / abuse		Eating concerns
	Grief / loss		Childhood trauma		Family issues
	Other (Please specify)				

SYMPTOMS/BEHAVIORS (Check all that apply)

- ☐ Eating less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor concentration
- ☐ Crying
- ☐ Withdrawing socially
- ☐ Binge drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Depressed
- ☐ Shameful
- ☐ Sad
- ☐ Stressed
- ☐ Afraid
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Out of control
- ☐ Numb
- ☐ Irritability
- ☐ Acting out sexually
- ☐ Acting aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Unhappy
- ☐ Recklessness
- ☐ Anxious
- ☐ Passivity
- ☐ Drug use
- ☐ Alcohol use
- ☐ Socializing
- ☐ Parent/child conflicts
- ☐ Lack of ambition/goals
- ☐ Poor peer relationships

PHYSICAL SYMPTOMS (check all that apply)

- ☐ Insomnia
- ☐ Tired
- ☐ Weight gain or loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness in chest
- ☐ Vomiting
- ☐ Rapid heart beat
- ☐ Dry mouth
- ☐ Excessive sleep

Do you have the legal right to seek and authorize treatment for this minor child? _____
(If applicable, a copy of the legal document stating your rights is required.)

The information provided by me/us is true and accurate. I have provided a copy of our legal custody agreement if applicable.

Parent/Guardian Signature _____ Date: _____