## Minor Intake Form

Name of ***child***       Name of ***parent(s)***       Today’s Date

Nickname:       Date of Birth:       Child's age:       Child's gender:

Child's **Primary** **Address**

City       State       Zip Code

Home Phone       Parent’s Cell

May we leave a voicemail on your home phone? [ ]  Yes [ ]  No On your cell phone? [ ]  Yes [ ]  No

Parent’s email address

Second Emergency Contact for Child

Relationship       Telephone (C)

What is your child’s living arrangement?

What is the custody arrangement with your child?

Are there any legal matters involving your family at this time? If so, please explain:

Do you or your child have any restraining orders against anyone?       If so, please explain

Are you divorced?       How old was your child?       Did you remarry?

If so, when and how old was your child

Does your child have siblings?       If so, how many?       What is your child's birth order?

**Secondary Address** (other parent’s home, if applicable)

City       State       Zip Code

Home Phone       Cell Phone

Work Phone       Which of these is the best way to reach you?

With whom does your child live at this residence?

How often is your child at this residence?

Email Address:

Does your child have a good support system?       Is the family part of the support system?

Please give the following information for each person that currently lives in your home, ***including yourself and your child***:

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship to Self |
|       |       |       |
|       |       |       |
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Please also list any other people in your immediate family who may not be living in your house:

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship to Self |
|       |       |       |
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**Personal and Medical Information:**

Is your child currently taking any prescription medications?       If so, please list the name of the medication, what it was prescribed for and by whom it was prescribed:

Who is your child's primary physician? (name, phone number and fax)

List any other past or present medical issues for your child:

List any secondary issues, (sleeplessness, constant worry, phobias, etc...):

Date of child’s last physical:

Note any significant events occurring at this time (trouble in school, death in family, divorce of

parents, etc.):

List any emotional issues that are present (anger, anxiety, moodiness, etc...):

Are there areas of personal struggle? (i.e. aggression, pornography, eating disorder, lying, stealing, etc…):

Has your child had thoughts of harming themselves or ending their life?

**Family History (**please include **you,** your **spouse,** your **child** & **extended family** when appropriate):

Alcoholism/Drug Abuse:

Depression, Manic/Depression, Schizophrenia:

**Other Background Information:**

Where does your child attend school?       Grade level?

Does your child currently attend church?       Which one?

Your Occupation:       Spouse’s:

Has your child ever seen a therapist before?

If so, when did he/she receive counseling?

Was his/her previous counseling helpful?

What brings your child here **today** for counseling?

1.

2.

3.

4.

5.

Family Problems/Difficulties going on at this time?

How is your child's school performance?

Are there any major discipline problems at school (suspensions, expulsions, etc...)?

Are there areas of discipline problems at home? Describe your child's overall mood

Does your child have any sleep difficulties (nightmares, frequent waking up, difficulty falling asleep, not sleeping in own bed, etc...)?

Describe your child's energy level

Describe your child's social interaction with others/friends

Is there any abuse history? (sexual, emotional, or physical)

Has your child witnessed any domestic violence or other traumatic events?

What does your child enjoy doing?

What are your child's strengths?

**Timeline of Significant Events** (positive and negative; i.e. birth of sibling, parental separation, death in family, school, milestones, family move, friends):

Birth

-

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Present Age

**Treatment Planning:**

What are your goals for bringing your child to counseling?

1.

2.

3.

4.

5.

6.

Additional treatment goals if applicable (for office use only):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about One:12 Counseling?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_