Positive Change Counseling Services
A Professional Corporation of Marriage and Family Therapists
850 Merchant Street, Suite A
Vacaville, CA 95688
(707) 446-8600

Minor Intake Paperwork

Today's Date_____

Referred By_____

Please take time to fill out this form. This will aid greatly in providing appropriate therapeutic care for your child.

Name of Child_____ Date of Birth_____

- Name of parent_____ Date of Birth_____

  Address_____ City_____ Zip_____

  Phone_____ Email_____
- Name of parent_____ Date of Birth_____

  Address_____ City_____ Zip_____

  Phone_____ Email_____

Are there any custody issues? __Yes __No

If so, what are the legal stipulations? _____
_____

Current school_____ City_____

Emergency Contact_____ Phone_____

Relationship to Client_____Address_____

Current Living Situation

Please circle which of the following best describes your child's living situation.

Rent apartment	Shelter
Rent house	Homeless
Own house	Group home
Foster care	Residential treatment

Support System

List the household members living in your child's home.

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

List important friends, family members or relatives living outside of your child's home.

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Name_____ Age_____ Relationship to you_____

Areas of Concern

What issues/concerns cause you to seek treatment for your child? Please describe.

_____
_____
_____

When did the problems start? _____

What would you like your child to achieve in therapy?

_____
_____
_____

Do you have any concerns or fears about therapy? __Yes __No

If yes, please describe _____

Psychological History

Name of previous therapist_____ Phone_____

Dates of treatment_____ Focus of treatment_____

What was helpful/not helpful about treatment?_____
_____

Has your child had psychological testing?_____ If yes, by whom?_____

Has your child ever had suicidal or homicidal

- Thoughts?_____
- Attempts?_____

Has your child been hospitalized for mental or emotional problems? __Yes __No

If so,

- When?_____
- How long?_____
- What was the reason?_____

Hospital Name_____

Current Medications

1. Name of medication_____ Dose_____
   Start Date_____ Prescribed by_____Phone_____
2. Name of medication_____ Dose_____
   Start Date_____ Prescribed by_____Phone_____
3. Name of medication_____ Dose_____
   Start Date_____ Prescribed by_____Phone_____
4. Name of medication_____Dose_____
   Start Date_____ Prescribed by_____Phone_____

Medical History

Has your child ever been diagnosed with a serious illness?

Please describe_____

Date of last physical exam_____ Physician_____ Phone_____

Is your child experiencing any medical/physical symptoms you attribute to emotional, or stress-related condition? Please describe_____

Are you concerned your child is using alcohol or drugs? __Yes __No

If yes,

- What makes you think so?_____
- What has been done to reduce risk?_____
- Has law enforcement been involved?_____

Family of Origin History

Description of your child's relationship with Mother.

_____
_____
_____

Description of your child's relationship with Father.

_____
_____
_____

Please describe your child's experience

- At home

  _____
  _____
  _____

- At school

  _____
  _____
  _____

Has your child ever subjected to abuse? __Yes __No

If yes, please describe verbal, bullying, physical, and/or emotional abuse.

_____
_____
_____

Has your child ever been a victim of a violent crime? Please describe.

_____
_____
_____

Early Development

Were there birthing complications? ___ Yes __No

If yes, please describe_____

Was the baby unwanted by either parent? __Yes __No

Please check any issue that applied to your child in the early years.

__Bed wetting	__Head banging	__Rocking
__Sleeping problems	__Grind teeth	__Avoid eye contact
__Feeding problems	__Flapping hands/twirling fingers	__Using "I" properly
__Focus on spinning objects	__Seeming in own world	__Tantrums
__Over cautious	__Fearful	__Avoid new situations
__Accident prone	__Lack of ability to focus	__Poor coordination
__Avoid new people	__Depressed mood	__Nail biting

Check any task your child did NOT accomplish at normal age.

__Crawl	__Dress self	__Tie shoes
__Walk	__Ride a bike	__First word
__Feed self	__Three-word sentence	__Toilet training
__Write legibly	__Manipulate small toys	__Puzzles

How was your child disciplined by each parent?_____
_____

Were there times discipline got out of control? __Yes __No

Academics

Age of child when entered school_____

How did your child react to separating from caregivers to go to school?_____
_____
_____

Grades

- In elementary school_____
- In middle school_____
- In high school_____

Identified problems

Has your child been in trouble at school? __Yes __No

If yes,

- Please describe
  _____
  _____
- When did they begin?_____
- What has been done to help?_____

Does your child have an IEP in place? __Yes __No

Other Information

Spiritual identity/Orientation_____

Interests/Hobbies_____

Has Child Protective Services ever been involved? __Yes __No

Is your child involved with legal problems? __Yes __No If yes, for what?_____

Areas of Concern

Please check any areas you are concerned about. Check all that apply.

__Depression	__Strange behaviors	__Lack of friends
__Crying a lot	__Paranoia	__Avoid others
__Sexual abuse	__Destroy things	__Lack of attention
__Obsessive thoughts	__Learning difficulties	__Stealing
__Anxiety	__Promiscuity	__Panic attacks
__Physical abuse	__Hopelessness	__Self injurious behaviors
__Weight loss	__Suicidal thoughts/plans	__Vandalism
__Hot temper	__Odd beliefs	__Fire setting
__Gambling	__Substance use	__Violence
__Nightmares	__Hyperactivity	__Physical problems
__Worry excessively	__Perfectionist	

Strengths

Please check any areas you consider your child's strengths. Check all that apply.

__Employed	__Easy going	__Athletic
__Independent	__Regularly copes well	__Structures time well
__Intelligent	__Caring	__Loyal
__Responsible	__Honest	__Positive outlook
__Spiritual	__Helpful	__Artistic
__Playful	__Good looking	__A leader

Thank you for taking the time to fill out this intake form.

_____

Printed Name Signature Date

Appointment Reminders:

I consent to receive appointment reminders from Positive Change Counseling Services in the following formats (check any/all that apply):

- ☐ Email
- ☐ Text Message
- ☐ Phone Call

_____

Printed Name Signature Date