2020 Confidential Minor Intake Form

Kid Power Counseling

Date

Month Day Year

Referred By

Child Date Of Birth

Month Day Year

Child's Name *

First Name Middle Name Last Name

Phone Number: *

(123) 456-7890

Social Security Number

Parent or Legal Guardian Name *

First Name Middle Name Last Name

Mailing Address: *

Street Address

Street Address Line 2

City State

Zip Code

E-mail *

example@example.com

Father's Name

First Name Middle Name Last Name

Father's Employer

Work Number

Area Code Phone Number

Mother's Name

First Name Middle Name Last Name

Mother's Employer

Work Number

Area Code Phone Number

If needed, may we contact you at work?

☐ Yes ☐ No

Marital Status Of Parents

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Deceased

If parents are separated or divorced, parent child is living with and custody arrangements

Siblings Names (include Step) and Birthdates

And Address (if different)

Additional Comments on Parents Martial History

School History (School, Grade, Age, Dates)

Church Affiliation (if any) and Name of Pastor/Rabbi/Priest

Is Minor Under Medical Treatment?

- [ ] No
- [ ] Yes
- [ ]

Is Minor Taking Medication?

- [ ] No
- [ ] Yes
- [ ]

Please describe any current or chronic diagnosed medical conditions

Is minor currently involved in any legal matters, including custody disputes or insurance settlements?

Prior Counseling Experiences

	Counselor Name	Length of Counseling	Dates	Location
Counselor				
Counselor				

Reason for seeking counseling? (describe problem, including length and precipitating event (if any)

Goals for Counseling

Please Check Appropriate Responses

- ☐ Current or previous alcohol or drug abuse
- ☐ Family current or previous alcohol or drug abuse
- ☐ Anger difficulty
- ☐ History of physical abuse
- ☐ Changes in level of energy
- ☐ Behavior problems
- ☐ Recent move
- ☐ School difficulties
- ☐ Eating disorders
- ☐ Habits minor is struggling with
- ☐ History of sexual abuse
- ☐ Changes in sleep
- ☐ Changes in eating habits
- ☐ Parents arguing frequently
- ☐ Recent loss of loved one
- ☐ Anxiety difficulties

To your knowledge, has the minor ever had suicidal thoughts?

- ☐ Yes, current
- ☐ Yes, Past
- ☐ None

If yes to suicidal thoughts, please explain.

Give a brief description of child's life stressors from ages 1 to 3.

Give a brief history of minor's relationship with

Father

Give a brief history of minor's relationship with

Mother

Give a brief history of minor's relationship with

Brothers/Sisters

Give a brief history of minor's relationship with

Spouse

Give a brief history of minor's relationship with

Children

Any additional comments you would like to tell us about the minor?

Individual Providing Minor's Information

First Name Middle Name Last Name

Signature