HIGHER HEIGHTS COUNSELING
YOUTH INTAKE FORM

Welcome **to Higher Heights Counseling Services**! Parents, please be sure that this form is completed prior to your first session so that we can gain a better understanding of your background, concerns and goals for counseling.

Youth Name: _____ Date of Birth: _____

Address:_____

Home Phone:_____ Primary Parent Cell: _____

Family History

Father Name _____Age: _____ Bus/Cell _____

Lives in home with child: _____ if not, actively involved with child: _____If deceased, date_____

Mother Name _____Age: _____ Bus/Cell _____

Lives in home with child: _____ if not, actively involved with child: _____If deceased, date_____

If the Child's parents are not currently married, please describe below (dates of adoption, divorce, remarriage, names of step-parents, and/or other relevant information):

_____

_____

Brothers/Sisters Names Age Sex Grade Living in home? Deceased? If so, when?

_____

_____

_____

Are both parents in agreement with bringing him/ her for counseling? Yes☐ No☐

Please describe any recent changes for your family (births, deaths, moves, accidents, etc):_____

_____

Therapy Information

Person completing form:_____ Relationship to child:_____

Reason for counseling:_____

_____

Previous Therapy? Yes☐ No☐ If Yes, please explain:_____

_____

How does your child/ adolescent feel about counseling at this time? _____

_____

In what way would you like counseling to help your child/ adolescent? _____

_____

What family members are likely/willing to participate in your child's counseling? _____

_____

Developmental and Educational Background

Did your child generally meet developmental milestones (i.e., walking, talking, etc.) on time?

Explain any developmental concerns: _____

Current Grade: _____Name of School:_____

Please describe any difficulties your child/adolescent is having in school: _____

_____

Has your child ever been psychologically tested? Yes☐ No☐ if Yes, when? _____

Religious and Spiritual Background

Does your child/ adolescent attend church? Yes☐ No☐ Name of Church: _____

What role does spirituality play in his/ her life? _____

Medical Background History

Physician: _____ City: _____

Last seen (approximately): _____ For: _____

On-going Medical Conditions: _____

Is your child/adolescent taking any prescription medication? Yes☐ No☐

Medication: _____ Treating: _____ Dosage: _____ Since: _____

Medication: _____ Treating: _____ Dosage: _____ Since: _____

Side effects? _____

Has your child had a recent hearing exam? Yes☐ No☐ Eye exam? Yes☐ No☐

Any problems? Yes☐ No☐ If yes, please explain:_____

_____

Does your child use (or ever) used drugs or alcohol? Yes☐ No ☐ If yes, please explain:_____

_____

Family history of substance abuse? Yes☐ No ☐ If yes, please explain any exposure / adverse affect on child:_____

_____

Please check any areas of concern:

--- Moody --- Sad --- Concentration ---Anxious/worries ---Cannot sleep

---- Shy --- Defiant --- Poor Appetite --- Low energy ---- Has been abused ---

---- Has been bullied --- Has bullied others ---Has abused others ---Homicidal or Suicidal thoughts

Please explain any of the above marked: _____

_____

Has he/she ever been in any serious trouble? ☐Yes ☐No If yes, explain:

_____

_____

Please check areas of relative strength or giftedness:

--- Compassionate Athletics ---Reading --- Determined ---Insightful

Creative Coordinated ---Math ---- Academics Loving

--- Sensitive --- Reflective --- Independent ---Sense of Humor ---Social

Please explain any of the above: _____

_____

Is there anything that would be good for your counselor to know? (use back if needed)

_____

_____

_____

_____

_____

Parent / Guardian Signature: _____Date:_____

Submit Reset Form