**Minor Child Intake Form**

**New Day Counseling**

**Mountain View MO Counseling Center, LLC.**

Please provide the following information about your minor child: DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nick Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_Grade:\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Child's biological parents: Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has legal guardianship of your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we leave a voice message? \_\_\_\_\_\_ A text message? \_\_\_\_\_\_

Who are other household members living with your child?

**Names Ages Relationship to child**

Who are your child's significant others NOT living with your child?

**Names Ages Relationship to child**

Please describe any past counseling & outcomes that your child has received.

Dates:

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? \_\_\_\_\_\_

if yes, please describe:

**Education History:** What does your child's teacher or other educators / coaches / church workers say about him/her?

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Has your child ever repeated a grade? If so which one(s)?

Has your child ever received special education services?

Has your child experienced any of the following problems at School?

Fighting Lack of friends Drug/Alcohol Detention

Suspension Learning Disabilities Poor attendance Poor grades

Gang influence Incomplete homework Behavior problems

**Medical History:**

Name of your child's primary care physician & office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your child's last medical examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Has your child experienced any of the following medical problems?

A serious accident Hospitalization Surgery Loss of Consciousness

A head injury High fever Convulsions/seizures Asthma

Eye/ear problems Meningitis Hearing problems Allergies

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

**Other History:**

Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

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Has he/she ever purposely hurt himself or another? \_\_\_\_\_\_ If yes to either question, please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain with approximate dates or age of child at the time:

Please consider and list any things that are currently stressful to your child and his/her family?

**Are there any Behavioral Excesses or Behavioral Deficits you would like addressed:**

What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Deficits: What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Strengths: What does your child do that you like? That other people like?

**Treatment Goals**:

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

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**Consent to Counsel a Minor**

**New Day Counseling**

Mountain View MO Counseling Center, LLC

1. The minor(s) named below live in my home and I am 18 years of age or older. Yes No
2. Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

1. Your Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Your relationship to child(ren): Parent Stepparent Guardian Grandparent
3. I hereby swear that I have the following **legal custody** (circle appropriate): Joint Sole None
4. I hereby swear that I have a legal right to obtain treatment for the above-named child: yes no
5. In instances of divorce, it is essential that the legal custodian of the child(ren) grant permission for the services. If you are a divorced parent, a stepparent, a grandparent, a guardian, or other, you may be asked to provide a copy of the court order which names you the legal custodian of the above child(ren). Are you willing to do so? Yes No

***If the answer to any of the above questions is “No,” counseling services can not be provided to the above-named child(ren) until a copy of the court order which names you the legal custodian is provided to this office.***

* I have read, understand, and agree to the *Confidentiality Statement* and the *Informed Consent/Duty to Warn* (exceptions to confidentiality) for New Day Counseling, Mountain View MO Counseling Ctr., LLC.
* I am aware of its content and policies and understand that a copy of this *Signature Statement* will be a part of my case record.
* I have read it and if necessary, I have discussed and clarified my understanding of it with a representative of the Mountain View MO Counseling Center, LLC.
* I agree to abide by the terms/policies set forth in this document.
* I consent to have the above named minor(s) receive therapeutic services provided through New Day Counseling, of Mountain View MO Counseling Ctr., LLC., (MVMOCC) without a parent or guardian present.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of person authorizing consent of services Date

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Signature of Witness Date

Mountain View MO Counseling Center, LLC