Minor Intake Form

Client Information:

Full Name of Minor: _____

Preferred Name/Nickname (if any): _____

Date of Birth: _____ **Age:** _____

Gender: _____ **Pronouns:** _____

School Name & Grade Level: _____

Primary Language Spoken: _____

Allergies or Medical Conditions:

_____

_____

Current Medications (if any):

_____

_____

Parent/Guardian Information:

Name of Parent/Guardian #1: _____

Relationship to Minor: _____

Phone Number (Home): _____

Phone Number (Cell): _____

Email Address: _____

Primary Address: (Street, City, State, ZIP)

_____

_____

Name of Parent/Guardian #2 (if applicable): _____

Relationship to Minor: _____

Phone Number (Home): _____

Phone Number (Cell): _____

Email Address: _____

Emergency Contact (if different from parent/guardian):

Full Name: _____

Relationship to Minor: _____

Phone Number (Cell): _____

Reason for Seeking Therapy:

- **Primary Reason for Visit (Briefly describe what the minor is experiencing or what concerns led to seeking therapy):**

- **Has the minor ever received therapy or counseling before?**
  ☐ Yes ☐ No
  If yes, please provide details (therapist name, dates of treatment, reason for therapy):

- **Has the minor experienced any of the following? (Check all that apply)**
  ☐ Anxiety ☐ Depression ☐ Trauma or abuse ☐ Family issues ☐ School problems ☐ Behavioral issues ☐ Self-harm ☐ Thoughts of suicide ☐ Substance use ☐ Other (Please describe):

Mental Health and Family History:

- **Is there a family history of mental health conditions or substance use?**
  ☐ Yes ☐ No
  If yes, please specify the condition(s) and family member(s) involved:

- **Does the minor have any significant medical or developmental history (e.g., ADHD, learning disabilities)?**
  ☐ Yes ☐ No
  If yes, please describe:

- **Is the minor currently involved in any other mental health or medical treatments (e.g., psychiatrist, counselor, pediatrician)?**
  ☐ Yes ☐ No
  If yes, please provide details:

Parent/Guardian Consent:

- I, the undersigned, authorize therapy services for my child, by the therapist at Blended Together Counseling. I understand that therapy may involve discussion of emotional, behavioral, and psychological topics, and I have been informed of the therapy process.
- **Signature of Parent/Guardian:** _____
- **Date:** _____

Important Notice:
Confidentiality is important in therapy, but limits do exist. Information shared in therapy may be disclosed if there is a risk of harm to the minor or others, or if required by law. Please refer to the clinic's confidentiality agreement for more details.
