Anna Stewart, MA, LMFT
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Minor/Child Intake Form

Date: ______________________ Client Name:_______________________

What are the issues that led you to decide to bring your child to therapy? ________________________
____
____

Has your child received prior therapy related to any of the above concerns? ___Yes ___No

If yes, when: _______________________ Length of treatment: _______________________

What was the outcome (check one)?

___Very Successful ___Somewhat Successful ___Stayed the Same ___Somewhat worse ___Much Worse

What do you hope to accomplish in therapy for your child? ____________________________________
____
____

Does your child want to attend therapy? ____Yes ____No

Please list siblings of the child (including step, foster, adopted):

Name	Sex	Age	Relationship to child	Describe him/her

Please rate how much support you and your family have overall:

1	2	3	4	5
None	Very Little	Limited	Some	A lot

What is your child's relationship like with other members of your family? _________________________
____
____

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Are there any cultural, religious, spiritual, or ethnic factors for your family that you would like me to be aware of? ____Yes ____No
If yes, please describe: ____
____
____

What does your child enjoy doing in his or her free time, either on his/her own or with others? ________
____
____

What are your child's strengths and limitations? ____
____
____

Where there any issues during the pregnancy or labor with your child? ____Yes ____No
If yes, please describe: ____
____
____

How would you describe your child as a baby? (fussy, happy, difficult etc.) ______________________
____
____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, financial problems etc. in the last several years? ____Yes ____No
If yes, please describe: ____
____
____

Has there been any verbal____, emotional___, physical___, or sexual___ abuse that has happened to your child that you are aware of? ____None
If yes, was the assailant someone your child knew? ____Yes ____No
If yes, relationship to child ________________
Where is this person now? ____

Has your child ever been involved with Child Protective Services? ____Yes ____No
If yes, please describe: ____
____

Has your child ever had any legal issues? ____Yes _____No
If yes, please describe: ____

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Is your child currently experiencing any suicidal thoughts? ____Yes ____No
Has your child had a suicidal attempt? ____Yes ____No
If yes, date of last attempt and treatment: ____
____
____

Has anyone in the family ever been hospitalized for psychiatric reasons? ____Yes ____No
If yes, please describe: ____
____
____

Does anyone in the family have any know mental health diagnoses? ____Yes ____No
If yes, please describe who and their diagnosis: ______________________________________
____
____

Does your child have a medical provider? ____Yes ____No
Name:____Phone:____________________

Does your child have any medical issues? ____Yes ____No
If yes, please describe: ____
____
____

Please list any medications your child is currently taking, or has taken during the past 6 months.
(Include prescribed and over the counter medications)

Medication	Dosage	Used for	Prescribing Doctor

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Please share information about the substances that you know/believe that **your child** has used within the past year. Include street drugs and misuse of prescription medication.

Substance	How much and how often	When last used?	Age started using
Caffeine			
Tobacco			
Alcohol			
Marijuana/Pot			
Cocaine/Crack			
Opiates/Narcotics (i.e. pain killers)			
Barbiturates/Sedatives/Tranquilizers			
Amphetamines/Stimulants			
Hallucinogens/LSD/Psychedelics			
Other:			

Please share information about substance use by **other people** who are significant in your child's life.

Substance	Relationship to Client?	How much and how often?	When last used?
Caffeine			
Tobacco			
Alcohol			
Marijuana/Pot			
Cocaine/Crack			
Opiates/Narcotics (i.e. pain killers)			
Barbiturates/Sedatives/Tranquilizers			
Amphetamines/Stimulants			
Hallucinogens/LSD/Psychedelics			

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Does your child do things that other people might think are impulsive, risky, or dangerous?
____Yes ____No
If yes, please describe: ____
____
____

Check any of the following symptoms or concerns that your child is currently or has recently experienced:

__Stress	__Aggression	__Depression
__Chronic Pain	__Eating problems	__Gender identity
__Loneliness	__Controlling	__Trouble sleeping
__Fatigue	__Obsessive thoughts	__Unwanted memories
__Relational issues	__Hearing voices	__Pregnancy/Abortion
__Low self-esteem	__Racing thoughts	__Anxiety
__Compulsive behavior	__Loss of control	__Fears
__Grief	__Drug/Alcohol use	__Panic
__Sexual addiction	__Impulsive behavior	__Anger
__Poor Concentration	__Sexual concerns	__Bad dreams

If your child is a student, does he or she enjoy school? ____Yes ____No
If no, please describe: ____
____
____

What are your child's peer relationships like? ____
____
____

Any other information you think is important for me to know? _________________________________
____
____
____