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Child/Minor Client Intake Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: ____ M ____ F

Address

_____

_____

School: _____

Grade: _____ Teacher: _____

Name of Parent(s)/Guardian(s)

Name:_____ Relationship: _____

Name: _____ Relationship: _____

Parent(s): ____ Single ____ Partnered ____ Married ____ Separated ____ Divorced

Is your child adopted? ____ Y ____ N **If YES, do(es) he/she/they know? ____ Y ____ N

Do you have an existing Guardianship, Custody and/or Visitation agreement regarding your child(ren)? ____Y ____ N
*Note: You may be asked to provide a copy for your child(ren's) records

Contact Information

Mother(s)/Guardian(s) Preferred Phone: _____ (___ H, ____ W, ____ C)

Father(s)/Guardian(s) Preferred Phone: _____ (___ H, ____ W, ____ C)

I/We_____,
as the responsible parent(s)/guardian(s), do hereby authorize counseling to be provided to the above named minor(s).

Signature: _____ Date: _____

Signature: _____ Date: _____

In order to obtain a more comprehensive understanding of your child and your family, please complete this form. Feel free to leave any question blank, but also consider that more information may allow me the opportunity to tailor the treatment plan to effectively meet your child's needs.

What prompted you to seek services?

_____

_____

_____

_____

How long has this been a problem? _____

Does your child/children view themselves as having a problem? ____ No ____ Yes

If YES, how would he/she/they describe the problem?

_____

_____

What specific symptoms/problems do you think are relevant? Please check all that apply

Physical

___ Frequent complaints of: fatigue, headache, stomach ache, etc.

___ Fidgeting/Unable to Relax

___ Trembling/Shaking/Tremors

___ Changes to Sleep Patterns

___ Changes in Appetite/Eating Patterns

Mental

___ Racing Thoughts

___ Obsessions (thoughts, etc.)

___ Suicidal Thoughts/Homicidal Thoughts

___ Recurring, Distressing Dreams

___ Difficulty Concentrating

___ Hallucinations (Auditory,Visual, Etc) / Delusions (Detachment from Reality - Paranoid, Grandiosity, Etc.)

___ Nightmares about Traumatic Experience(s)

___ Frequent Worry Phobias/Unusual Fears about Specific Things

___ Recurring, Distressing Thoughts about Trauma "Flashbacks" as if relivingTraumatic Experience(s)

Emotional

___ Mood Swings
___ Irritability
___ Crying
___ Clinginess/Separation Anxiety

Behavioral

___ Change in friends/relationships
___ Suicide Attempt(s)
___ Drug Abuse
___ Alcohol Abuse
___ Lying
___ Anger Outbursts
___ Running Away
___ Withdrawal
___ Isolation
___ Blaming
___ Using/Manipulating
___ Self Harm/Mutilation

In the space below, please feel free to further explain any of the above items

_____

_____

_____

_____

Parental/Family Information

Children in the home

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If parents are Separated or Divorced

How long have you been separated or divorced? _____

How old was/were your child(ren) at this time? _____

Has either parent remarried? ____ Y ____ N If Yes, how long ago? _____

How has/have your child(ren) responded to this?

_____

_____

Does your new spouse have children? ____Y ____ N

If yes, how many? _____ (____ Girl(s), ____ Boy(s)

How has/have your child(ren) responded to this?

_____

_____

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)

_____

_____

_____

Any other information I should have/know about your child/their relationship with you?

_____

_____

_____