MINOR INTAKE FORM

Thank you for taking the time to help me understand your child. Please answer what you can; if a question does not apply or you prefer to discuss it in session, you may write "N/A" or "discuss."

1. Child and Caregiver Information

Child's legal name: _____ Preferred name: _____

Date of birth: _____ Age: _____ Pronouns: _____ Grade: _____

Child's primary address: _____

Parent/Legal Guardian 1: _____ Relationship: _____

Phone: _____ Email: _____

Address, if different: _____

Parent/Legal Guardian 2, if applicable: _____ Relationship: _____

Phone: _____ Email: _____

Address, if different: _____

Who lives in the child's household(s)? Please include names, ages, relationships, and the usual schedule.

_____

_____

_____

2. Legal Authority, Custody, and Family Circumstances

Parents/guardians are: ☐ together ☐ separated ☐ divorced ☐ never married ☐ other: _____

Legal decision-making/custody: ☐ joint ☐ sole ☐ guardianship ☐ other: _____

Parenting time/physical custody: ☐ shared ☐ primarily Guardian 1 ☐ primarily Guardian 2 ☐ other: _____

Is there current or anticipated court, custody, DCFS, or child-welfare involvement? ☐ No ☐ Yes

Are there orders limiting contact, access to records, or decision-making? ☐ No ☐ Yes

Who has authority to consent to treatment? _____

If applicable, provide the Practice with complete, current custody/guardianship orders, parenting plans, and any required consents before services begin. Treatment may be delayed while legal authority is clarified.

3. Referral, Concerns, and Goals

Referred by: _____ Relationship/organization: _____

What brings you in now? _____

_____

_____

_____

Primary concerns (check all that apply):

☐ anxiety/worry ☐ mood/sadness ☐ emotion regulation/meltdowns ☐ attention/impulsivity ☐ behavior/defiance
☐ aggression ☐ school avoidance ☐ learning ☐ autism/social communication ☐ peer relationships ☐ grief/trauma
☐ sleep ☐ feeding/toileting ☐ sensory differences ☐ family transitions ☐ other: _____

What would you most like therapy to help with? _____

_____

_____

4. Strengths, Interests, Identity, and Relationships

What does your child enjoy, do well, or feel proud of?

_____

_____

_____

Important relationships, communities, cultural identities, spiritual beliefs, or family values:

_____

_____

_____

How does your child communicate best, feel safe, and connect with others?

_____

_____

_____

5. Developmental and Medical History

Pregnancy/birth history, complications, prematurity, NICU stay, or prenatal exposures:

_____

_____

Milestone	Approximate age	Notes/concerns
Walking		
First words		
Short phrases		
Toilet training		

Developmental regression or loss of skills? ☐ No ☐ Yes — describe: _____

Hearing, vision, speech, motor, or toileting concerns? ☐ No ☐ Yes — describe: _____

Medical diagnoses, surgeries, seizures, head injuries, allergies, or other health concerns:

_____

_____

Current medications/supplements (name, dose, frequency, prescriber, and response):

_____

_____

Primary care provider: _____ Phone: _____

6. Mental Health and Treatment History

Prior counseling, evaluations, diagnoses, hospitalizations, or other services (include what helped or did not):

_____

_____

_____

Family history of mental health, neurodevelopmental, learning, substance-use, or neurological concerns:

_____

_____

7. Safety and Significant Experiences

Has your child experienced or been exposed to any of the following? Check any that apply.

☐ major loss/grief ☐ family conflict ☐ separation/divorce ☐ bullying ☐ violence ☐ abuse/neglect
☐ serious illness/injury ☐ foster care/adoption disruption ☐ discrimination ☐ legal/DCFS involvement
☐ other significant stress or change: _____

Please share anything that would help me respond sensitively and safely. You may write "discuss" if preferred.

_____

_____

_____

Current or past concerns (check any that apply): ☐ suicidal thoughts ☐ suicide attempt ☐ self-harm
☐ harming others ☐ aggression ☐ running away/elopement ☐ unsafe sexual behavior ☐ access to weapons
☐ none known ☐ prefer to discuss

If checked, describe what happened, when, current risk, and safety steps already in place:

_____

_____

_____

If there is an immediate safety emergency, call 911 or go to the nearest emergency department. This form and routine Practice communication are not crisis services.

8. Emotion Regulation and Behavior

Behaviors/concerns: ☐ meltdowns ☐ aggression ☐ property destruction ☐ defiance ☐ self-injury
☐ withdrawal/shutdown ☐ panic ☐ elopement ☐ other: _____

Frequency: _____ Typical duration: _____

Common triggers or patterns (transitions, demands, sensory input, fatigue, hunger, conflict, etc.):

_____

_____

What helps your child calm, cope, communicate, or reconnect?

_____

_____

_____

9. Communication and Sensory Profile

Primary communication: ☐ conversational speech ☐ short phrases ☐ single words ☐ gestures/signs
☐ AAC/device/PECS ☐ other: _____

Communication or social concerns: ☐ following directions ☐ back-and-forth conversation ☐ understanding nonliteral language ☐ peer relationships ☐ expressing needs/emotions ☐ none ☐ other: _____

Sensory/routine needs: ☐ sound ☐ light ☐ touch/clothing ☐ food texture/smell ☐ movement/body input
☐ sameness/routines ☐ intense interests/repetitive movements ☐ none ☐ other: _____

Helpful accommodations, supports, or observations:

_____

_____

10. Sleep, Feeding, and Daily Routines

Typical bedtime: _____ Asleep by: _____ Wake time: _____ Naps: ☐ No ☐ Yes

Sleep concerns: ☐ trouble falling asleep ☐ night waking ☐ nightmares/terrors ☐ snoring/mouth breathing ☐ restless sleep ☐ bedwetting ☐ daytime sleepiness ☐ bedtime conflict ☐ none ☐ other: _____

Sleep supports or medications used: _____

Feeding/nutrition concerns: ☐ limited variety ☐ sensory aversions ☐ gagging/choking ☐ pocketing food ☐ long or stressful meals ☐ appetite/growth concerns ☐ GI concerns ☐ none ☐ other: _____

Preferred foods, avoided foods, allergies, and relevant mealtime supports:

_____

_____

_____

Other daily-living concerns (hygiene, dressing, toileting, transitions, routines):

_____

_____

11. Substance Exposure and Use

Exposure in home/vehicles: ☐ none known ☐ tobacco/vape ☐ cannabis ☐ alcohol ☐ other: _____

Are medications, alcohol, cannabis, nicotine products, and weapons securely stored? ☐ Yes ☐ No ☐ N/A

For youth age 12+: past-year use ☐ none ☐ nicotine/vape ☐ alcohol ☐ cannabis ☐ other: _____

If any use is reported: frequency/last use, related safety concerns, and interest in support:

_____

_____

12. School and Learning

School: _____ District: _____

Grade: _____ Teacher: _____ School contact: _____

Current supports: ☐ IEP ☐ 504 Plan ☐ academic support ☐ OT ☐ speech ☐ PT ☐ counseling/social work ☐ behavior plan ☐ social skills ☐ other: _____

Attendance, learning, behavior, discipline, bullying, or school-avoidance concerns:

_____

_____

_____

What helps your child succeed at school?

_____

_____

13. Digital Media and Online Safety

Average weekday use: _____ hours Average weekend use: _____ hours

Devices/activities: ☐ phone ☐ tablet ☐ computer ☐ gaming ☐ TV/streaming ☐ social media ☐ messaging

Concerns: ☐ difficulty stopping ☐ sleep disruption ☐ family conflict ☐ cyberbullying ☐ unsafe contacts ☐ sexual/violent content ☐ spending ☐ none ☐ other: _____

Supervision, parental controls, overnight device rules, and family goals:

14. Family Functioning and Current Stressors

Caregiver approaches, routines, rewards/consequences, and what works well:

Consistency between caregivers: ☐ high ☐ moderate ☐ low ☐ varies — comments:

Recent or ongoing changes/stressors (moves, losses, health, finances, conflict, legal matters, etc.):

Anything else you would like me to understand about your family?

15. Coordination of Care

Listing a provider does not authorize disclosure. Use the Practice Release of Confidential Information, available through the Practice or online.

Provider/role	Name/organization	Phone/email
Prescriber/psychiatrist		
School contact		
OT / SLP / PT / other		
Other		

16. Practice Communication and Administrative Acknowledgments

Scheduling and administrative communication. All scheduling, cancellations, paperwork, billing questions, and other administrative matters must go through the Dr. Jackie Jiang & Associates front office at 309-944-7833 or drjackiejiang@gmail.com. Appointment times and availability cannot be guaranteed.

Clinical communication. Clinical concerns or updates may be sent through the Practice email or front office and will be forwarded to Anna as appropriate. The front office cannot provide clinical advice. Anna will determine the clinically appropriate response, which may include addressing the matter during a scheduled session. Urgent or emergency concerns should not rely on email or voicemail.

Fees and billing. Fees, insurance billing, balances, cancellation/no-show charges, collections, and related financial matters are governed by current Dr. Jackie Jiang & Associates policies and applicable payer requirements. Questions should be directed to the front office.

Custody and records. I agree to promptly disclose changes in custody, guardianship, court involvement, contact restrictions, or decision-making authority and to provide complete, current documentation when applicable. I understand that the child—not either caregiver—is the identified client,

and that therapy is not intended to investigate custody disputes, mediate family conflict, or build a legal case.

Accuracy and updates. I have answered this intake form to the best of my knowledge and will notify the clinician or Practice of important changes. I understand that this form supplements, and does not replace, the Practice's informed-consent, privacy, telehealth, and financial policies.

17. Signatures

By signing, I confirm that I am authorized to provide this information and consent as represented above.

_____	_____	_____
Parent/Legal Guardian — printed name	Signature	Date
_____	_____	_____
Second Parent/Guardian, if required — printed name	Signature	Date
_____	_____	_____
Minor client, when clinically appropriate — printed name	Signature	Date

Additional Information

_____

_____

_____

_____

_____

_____