Sunlight Counseling, LLC

Child Intake Questionnaire

Thank you for completing this form and any others that you are given by *Sunlight Counseling, LLC*. The information you provide is confidential as outlined in *Sunlight Counseling, LLC* **Professional Disclosure** and **Notice of Privacy Practices** statements and will help your therapist create a treatment plan tailored to meet your needs and those of your family.

Date:_____/_____/_____

Client's Name:_____
(First) (MI) (Last)

Email:_____ Date of Birth:_____ Age:_____

Parent/Guardian Address:_____

May we leave a Message?

Telephone: (Home)_____ Yes___ No___ (Cell)_____ Yes___ No___

(Work)_____ Yes___ No___

Emergency Contact: Please provide the name of the person to contact in case of emergency.

Name:_____ Relationship to Client:_____

Address:_____ Telephone #1:_____

_____ Alternate Telephone:_____

Insurance Information

If using an insurance for payment, please provide your insurance card for photocopying.

Primary Insurance:_____ Secondary Insurance:_____

Education

Not in School:___ Grade:_____ School Attending:_____

Please list any issues with School/Learning:

Client's Siblings

Name	Date of Birth	Age	Living with You	Other Parent's Name
First			Yes___ No___	
Second			Yes___ No___	
Third			Yes___ No___	
Fourth			Yes___ No___	
Fifth			Yes___ No___	

Is there anyone living in your household other than parents or siblings? If so, please list:

Are Biological Parents Divorced or Separated? Yes___ No___ If yes—How long?_____

Is there Shared Custody with another Parent? Yes___ No___ If yes—Please list:

Name:_____ Telephone:_____

Address:_____

Are there presently any Child Custody issues involving you or your family? Yes___ No___

Does your family currently have Child Protective Services involved? Yes___ No___
If yes—Please provide the following: Case Worker's Name:_____
Telephone:_____ State:_____ County:_____

Other Agencies or Community Services involved?_____

Medical/Psychological History

Who is providing client's history information? Client___ Other_____

Has child/adolescent received or participated in Previous Counseling or Therapy? Yes___ No___
If yes—Who was the therapist?_____
When did they begin therapy and for how long?_____

Has child/adolescent ever been Hospitalized for Psychological Concerns? Yes___ No___
If yes—Please briefly explain:

Please describe the current complaint or problem as specifically as you can in your own words.

How long has child/adolescent experienced this problem, or when did you first notice it?

Please check all words/phrases that express what you are experiencing and explain if possible.

___Substance abuse/dependence – If so, what is/are your substance of choice?	___Anxious/nervous/tense feelings
___Addiction (internet, pornography, shopping, exercise, gaming, gambling, etc)	___Panic attacks
___Depression/sad/down feelings	___Racing/scrambled thoughts
___High/Low energy level	___Nightmares/flashbacks
___Angry/irritable	___Hearing voices/hallucinations
___Loss of interest in activities	___Thoughts of running away
___Difficulty enjoying things	___Paranoid thoughts
___Crying spells	___Feelings of being cheated
___Decreased motivation	___Perfectionism
___Withdrawing from people/isolation	___Rituals of counting things/washing hands/checking locks/stove/etc/overly concerned about germs
___Mood swings	___Dissatisfaction with body image
___Change in weight/appetite	___Concerns about dieting
___Change in sleeping patterns	___Feelings of loss of control regarding eating
___Suicidal thoughts or plans – hurting yourself	___Binge eating/purging
___Self harm (cutting, burning, etc) – If so, date of last experience:	___Excessive exercise
___Homicidal thoughts or plans – hurting others	___Rules about eating
___Poor concentration/difficulty focusing	___Indecisiveness about career
___Feelings of hopelessness/worthlessness	___Job problems
___Feelings of shame/guilt	___Other – If so, describe:
___Feelings of inadequacy/low self-esteem	

Has child/adolescent ever experienced any Significant Head Injuries? Yes___ No___

Current known Diagnosis:_____

Current Major Health Concerns:_____

Please explain any Allergies:

List current Medications (name, dosage, frequency):

Primary Care Physician? Yes___ No___

If yes—Please provide the following: Physician's Name:_____

Practice Name:_____ Telephone:_____

Any Abuse History? (physical, emotional, sexual) Yes___ No___

Please list any significant life events in the past 2 years? (moves, divorces, separations, deaths, trauma, etc)

Client's Personal and Social Resources and Strengths:_____

What Goals/Expectations do you have for counseling therapy?

Is there any Additional Information that you believe is important for the therapist to know? Please explain.

Referral Source

Were you referred to our office? Yes___ No___

If yes—By whom?_____

If no—How did you hear or learn about our office?_____

Treatment Contract

"I agree to receive (or agree that the client named above may receive) therapy at *Sunlight Counseling, LLC* and I acknowledge that I have received, read, understood and agreed to the terms outlined in the **Professional Disclosure** of *Sunlight Counseling, LLC*. I also acknowledge that I have received or have been offered a copy of the **Notice of Privacy Practices** of *Sunlight Counseling, LLC* and that I understood the contents thereof."

Print Client's Name:_____

Parent/Guardian's Signature:_____ Date:_____