Heartstrings Counseling
Healing Hearts, Healing Families

14400 W. Burnsville Parkway | Burnsville, MN 55306
PH 612.6181.1579 | FX 651.925.0415

INTAKE INFORMATION

Client name:_____

Today's date:_____ Date of birth:_____

Parent Name(s):_____

Reason for seeking counseling at that time _____
_____

Name of Children/Others in Household	Relationship	DOB	Lives with You?
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

Parent marital status: Single Married Divorced Widowed Separated

Who has legal custody of the child/children: _____

Who has physical custody of the child/children: _____

Address:_____

City:_____ State:_____ Zip code:_____

Home phone:_____ Ok to call? Yes No

Cell phone:_____ Ok to call? Yes No

Work phone:_____ Ok to call? Yes No

Email: _____

Okay to discuss scheduling via email Yes No

Okay to send statement or receipts per email? Yes No

Insurance Name: _____ Individual ID # _____

Group ID# _____ Phone Number on back of card _____

Date Insurance started: _____

Pregnancy
What substances, if any, did the mother use during the course or pregnancy (including before learning she was pregnant?

Alcohol: Describe amount and frequency _____
Tobacco: Describe amount and frequency _____
Street Drugs: Describe what drugs, amount, and frequency: _____
Prescription Drugs: Describe what drugs, amount, and frequency: _____

Heartstrings Counseling
Healing Hearts, Healing Families
14400 W. Burnsville Parkway | Burnsville, MN 55306
PH 612.6181.1579 | FX 651.925.0415

What medications did you use during your pregnancy and/or during delivery?
_____

Was this child/adolescent born __ less than 30 weeks gestation ____30-35 weeks gestation ____ 36-40 weeks _____ over 40 weeks

Was delivery ___ normal ____ Breach ____ Caesarian _____ Forceps/vacuum assisted _____ Induced

Birth Weight _____ lbs _____ oz

Infancy

Any current and/or past sleep pattern difficulties: ____ Yes _____ No
If yes, please specify:
_____

Any current and/or past eating concerns: _____ Yes _____ No
If yes, please specify _____

Any concerns with meeting developmental milestones: _____ Yes _____ No
If yes, please specify: _____

Describe any losses or separations which the child has experienced such as deaths. family relocations, etc and their impact on the child?
_____
_____
_____

Military
Does anyone in your family have military or combat experience? Yes _____ No_____

Effects on child and family? _____

Medical Info:
Name of Physician and/or clinic _____

Current Health Issues: _____

Medications _____ Dosage amount: _____ Prescribed by _____
_____ Dosage amount: _____ Prescribed by _____

Previous Therapists:
Name of Therapist / Clinic _____
Dates of Services: _____
Was it helpful? _____

Family Psychiatric Concerns
_____
_____
_____

Internet Concerns:
Do you have any concerns with your son or daughter using the Internet or electronic indications such as Facebook, Snap Chat, Twitter, texting (Y/N)

Heartstrings Counseling
Healing Hearts, Healing Families
14400 W. Burnsville Parkway | Burnsville, MN 55306
PH 612.6181.1579 | FX 651.925.0415

If yes, please explain
_____
_____

ACADEMIC INFORMATION:
SCHOOL _____ LOCATION: _____
IEP _____ Teacher _____

ANY CURRENT AND/OR PAST SCHOOL CONCERNS:
_____
_____

Strengths
What are the child's individual strengths?
1) _____
2) _____
3) _____

Child abuse
Yes _____ No _____
Type of abuse: (Please circle all that apply) Physical Sexual Mental Emotional Verbal
Ages that the abuse occurred_____ Who was the perpetrator?_____
Relationship to the child: _____

SUBSTANCE ABUSE:
Does your child drink alcohol? YES NO
If yes, what alcohol is he/she currently using or has used in the past?
_____
_____
Does your child/adolescent use drugs? YES NO
If yes, what drugs are you currently or used in the past?
_____
_____

Has your child ever had a chemical dependency assessment completed? When: _____

Who conducted the chemical dependency assessment? (Name/Organization)
_____

1. In the past 3 months, have you ever felt you should cut down, or stop drinking or use drugs?

2. In the last 3 months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or stop using drugs?

3. In the last 3 months, have you felt guilty or bad about how much you drink or use drugs?

4. In the last 3 months, have you woke up to have a drink to get rid of a hangover or steady your nerves?

Heartstrings Counseling
Healing Hearts, Healing Families

14400 W. Burnsville Parkway | Burnsville, MN 55306
PH 612.6181.1579 | FX 651.925.0415

Legal:
Any Current Legal Issues: _____
Any Past Legal Issues: _____

Does your child have a probation officer? Yes _____ No _____
Name: _____ Organization: _____
Telephone Number _____

Spirituality/Faith Background:
_____

Goals in Counseling **1.** _____
2._____
3._____

Risk Factors:
Self-Injury/Suicide: Yes _____ No _____ Self Injury Behavior Concerns? Yes _____ No _____

How did you learn of us?_____

Referred by:_____

Emergency Information

In case of emergency, contact:_____

Relationship:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____