

Minor Intake Form

Child's Name: _____ M/F _____ Date of Birth: _____

School Name: _____ Grade: _____

How were you referred to us: _____

<p>Mother's/Guardian's Information: Name: _____ Address: _____ _____ City State Zip Email Address: _____ Phone Number: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work May we leave a message: _____</p> <p><i>Note: Written and verbal client information supplied to us is confidential, however, we cannot guarantee the security of your email messages. Initial here to confirm that you have been informed of this. _____</i></p>	<p>Father's/Guardian's Information: Name: _____ Address: _____ _____ City State Zip Email Address: _____ Phone Number: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work May we leave a message: _____</p> <p><i>Note: Written and verbal client information supplied to us is confidential, however, we cannot guarantee the security of your email messages. Initial here to confirm that you have been informed of this. _____</i></p>
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FAMILY

Parents are: Married Divorced * Separated Committed Never Married
 Child lives with: Both Mom Dad Guardian

Who are other household members with your child?

Names	Ages	Relationship to child

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child

***Note: If child's parents are divorced, Arizona State Statutes require that Serenity First Counseling obtain the signed consent of both parents or have a custody agreement on file before the child can be seen by a therapist. NO EXCEPTIONS!**

MENTAL HEALTH HISTORY/STATUS

What are your concerns for your child?

Please check any symptoms your child may have had or is currently experiencing:

<input type="checkbox"/> Depression <input type="checkbox"/> Mood Swings <input type="checkbox"/> Anxiety <input type="checkbox"/> Remembering Past Traumas (nightmares, recurring memories) <input type="checkbox"/> Dissociation/Psychosis	<input type="checkbox"/> Drug/Alcohol <input type="checkbox"/> Abnormal Eating Behaviors <input type="checkbox"/> Behavior problems (fights, anger, fire setting, arguing, destruction of property) <input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Learning Disabilities <input type="checkbox"/> Harmed others <input type="checkbox"/> Attention/Hyperactivity Problem <input type="checkbox"/> Never Tired <input type="checkbox"/> Self-inflicted harm
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Please describe any past counseling that either your child or any family member has had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol?
 _____ If yes, please describe (including treatment):

What are your expectations for treatment?

MEDICAL HISTORY:

Has your child experienced any of the following medical problems?

<input type="checkbox"/> A serious accident <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Allergies <input type="checkbox"/> Broken bones	<input type="checkbox"/> A head injury <input type="checkbox"/> Asthma <input type="checkbox"/> High fever <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Other Explain:	<input type="checkbox"/> Convulsions/seizures <input type="checkbox"/> Eye/ear problems <input type="checkbox"/> Meningitis <input type="checkbox"/> Hearing problems
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Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

OTHER HISTORY

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Do you have any other concerns about your child or your family that you have not mentioned yet?