Minor Intake Form

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

School Name: _____ Grade: _____

How were you referred to us: _____

Mother's/Guardian's Info: DOB:_____

Name: _____

Address: _____

_____

City State Zip

Email Address: _____

Phone Number: _____

☐ Cell ☐ Home ☐ Work

May we leave a message: _____

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. _____

Father's/Guardian's Info: DOB: _____

Name: _____

Address: _____

_____

City State Zip

Email Address: _____

Phone Number: _____

☐ Cell ☐ Home ☐ Work

May we leave a message: _____

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. _____

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!

170 N. La Canada Dr. Suite 30C, Green Valley, AZ 85614 fax (520) 771-8291

MENTAL HEALTH HISTORY/STATUS

What are your concerns for your child?

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

☐ Depression ☐ Mood Swings ☐ Anxiety ☐ Remembering Past Traumas (nightmares, recurring memories) ☐ Dissociation/Psychosis	☐ Drug/Alcohol ☐ Abnormal Eating Behaviors ☐ Behavior problems (fights, anger, fire setting, arguing, destruction of property) ☐ Attempted Suicide	☐ Learning Disabilities ☐ Harmed others ☐ Attention/Hyperactivity Problem ☐ Never Tired ☐ Self-inflicted harm

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?

170 N. La Canada Dr. Suite 30C, Green Valley, AZ 85614 fax (520) 771-8291

MEDICAL HISTORY:

Has your child experienced any of the following medical problems?

☐ A serious accident ☐ Hospitalization ☐ Surgery ☐ Allergies ☐ Broken bones	☐ A head injury ☐ Asthma ☐ High fever ☐ Loss of consciousness ☐ Other Explain:	☐ Convulsions/seizures ☐ Eye/ear problems ☐ Meningitis ☐ Hearing problems

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?