



# 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: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work May we leave a message: _____  <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>	Father's/Guardian's Info:      DOB: _____ 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: _____  <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>
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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?

<b>Names</b>	<b>Ages</b>	<b>Relationship to child</b>
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Who are your child's significant others NOT living with your child?

<b>Names</b>	<b>Ages</b>	<b>Relationship to child</b>
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**\*Note: If child's parents are divorced, Arizona State Statutes require that JMS 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
_____ _____	_____ _____	_____ _____

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?

\_\_\_\_\_

\_\_\_\_\_