NEW MINOR CLIENT INTAKE FORM

PLEASE PRINT

TODAY'S DATE: _____ **HOME PHONE:** _____

CLIENT'S NAME: _____ **CELL:** _____

ADDRESS_____

CITY, STATE, ZIP: _____

D.O.B._____ **AGE:**_____

(IF STUDENT) SCHOOL: _____ **GRADE:** _____

E-Mail address:_____

REFERRED BY: _____

PARENT/ GUARDIAN:_____ **RELATIONSHIP:** _____

Family Physician: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Is your child presently under the care of a psychiatrist? Yes No
Psychiatrist Name: _____ Phone: _____
Does your child have any medical or mental health diagnoses?

_____

_____

Has your child been in counseling before? Yes No
What medication is your child presently taking and for what conditions?

_____

_____

Is your child on a particular diet at this time? Please describe.

_____

Please indicate any of the following symptoms your child has experienced:
___ Anxiety How long? _____

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___Depressed Mood	How long? _____
___Low energy level	How long? _____
___Racing thoughts	How long? _____
___Poor concentration	How long? _____
___Indecisiveness	How long? _____
___ Change in sleeping	How long? _____
___Change in appetite	How long? _____
___Angry outbursts	How long? _____
___Crying spells	How long? _____
___Lack of motivation	How long? _____
___Weight change	How long? _____
___Feeling others are against him/her	How long? _____
___Excessive guilt	How long? _____
___Isolation	How long? _____
___Mood swings	How long? _____
___Feelings of hopelessness	How long? _____
___ Low self-esteem	How long? _____
___Difficulty with memory	How long? _____
___Thoughts/plans of suicide	How long? _____
___Self-harm	How long? _____
___Thoughts/plans to hurt others	How long? _____
___Alcohol use	How long? _____
___Drug use	How long? _____
___Bedwetting	How long? _____
___Soiled pants	How long? _____
___Trouble in school	How long? _____
___Truancy	How long? _____
___Trouble with peers	How long? _____
___Disobedient	How long? _____
___Conflict with family	How long? _____
___Running away	How long? _____
___Problems with the law	How long? _____
___Rocking	How long? _____
___Head-banging	How long? _____
___Destructive	How long? _____
___Fire-setting	How long? _____
___Harm to animals	How long? _____
___Infantile	How long? _____
___Sexual behavior	How long? _____
___Lying	How long? _____
___Over-active	How long? _____
___Fearful	How long? _____
___Impulsive	How long? _____
___Phobic	How long? _____
___Other	How long? _____
___Other	How long? _____

Bio-psycho-social-spiritual History of Minor

Please describe the problem/ circumstances that led to you seeking counseling for your child:

_____

_____

What changes would you like to see in your child as a result of counseling:

_____

_____

_____

_____

Please list the name, age and relationship of everyone presently living with your child:

_____

_____

_____

Where was your child born? _____

Where has your child live?

_____ Age when living there _____ to _____

_____ Age when living there _____ to _____

_____ Age when living there _____ to _____

_____ Age when living there _____ to _____

How would you describe your economic status?

___ Lower class ____ Middle Class ____ Upper Middle Class ____ Upper Class

In what ways has this affected your child?

_____

_____

_____

Please describe your child's relationship with each of his/her parents:

Mother:

_____

_____

Father:

_____

_____

Please identify any history of divorce and/ or remarriage as related to the child's parents:

_____

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Please identify any significant relationships the child has had with step-parents:

Please describe any criminal history associated with either parents or step-parents:

Was your child adopted? Yes/No
Please describe the circumstances of the adoption:

Siblings (age, sex, and relationship):

Please describe any history of physical illness or injury in your family:

Please describe any history of psychiatric, emotional, drug/alcohol abuse, or other problems in your family:

Please describe any history of sexual, physical, or emotional abuse of your child:

Has your child has any history of drug/ alcohol abuse or eating disorders?

Has your child had any history of serious illness, injury or hospitalizations? Please describe.

Has your child experienced any developmental delays? Yes / No
If yes, please describe.

_____
_____
_____

Were there any problems with the pregnancy or delivery of your child?

_____
_____

What do you perceive to be your child's greatest strengths?

_____
_____

What areas of your child's life do you feel need improvement most?

_____
_____

Please describe discipline in your home and who enforces it.

_____
_____

Please describe the role of religion and spirituality in the environment where your child lives.

_____
_____

What churches or denominations has the family primarily attended?

_____

Are you comfortable incorporating your faith into the counseling process?

_____

Are you comfortable with prayer in counseling sessions? _____

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