INTAKE FOR MINORS

Client Name _____

Mother's Name: _____ Age: _____ Occupation: _____

Father's Name: _____ Age: _____ Occupation: _____

Or Legal Guardian: _____ Age: _____ Occupation: _____

Child lives with: ◯ Both Parents; ◯ Father; ◯ Mother; ◯ Other: _____

Parents: ◯ Live Together; ◯ are Divorced ◯ are Separated

◯ Remarried ◯ Deceased ◯ Other: _____

Primary Address: _____

HOUSEHOLD MEMBERS	RELATIONSHIP	BIRTHDATE/AGE

Secondary Address: _____

HOUSEHOLD MEMBERS	RELATIONSHIP	BIRTHDATE/AGE

ADDITIONAL INFORMATION RE: Custody, Guardianship, Legal Issues, etc. _____

_____

_____

MEDICAL HISTORY:

MEDICATIONS:

_____

_____

HAS YOUR CHILD HAD ANY ILLNESSESS? SURGERIES? HEAD INJURIES OR HOSPITALIZATIONS?

HOW WOULD YOU DESCRIBE YOUR CHILDS GENERAL HEALTH?

HAS YOUR CHILD BEEN DIAGNOSED WITH SOMETHING? IF SO WHAT?

BACKGROUND HISTORY

DESCRIPTION OF PROBLEM (what, who is involved, when did or does it occur)

WHY HAVE YOU CHOSEN TO SEEK COUNSELING AT THIS TIME?

HOW HAVE YOU TRIED TO SOLVE THE PROBLEM?

WHAT HAS BEEN SUCCESSFUL/UNSECCCESSFUL?

DESCRIBE YOUR PARENTING STYLE & APPROACH TO DISIPLINE

FAMILY HISTORY OF MENTAL ILLNESS

PREVIOUSE COUNSELING EXPERIENCE (with whom, client reaction, outcome):

PLEASE DESCRIBE ANY SIGNIFICANT TRAUMAS, LOSSES, OR SEPARATIONS YOUR CHILD OR FAMILY HAS EXPERIENCED:

HOW DOES YOUR CHILD GET ALONG WITH OTHER CHILDREN, ASULTS, & FAMILY MEMBERS?

HOW IS YOUR CHILD DOING IN SCHOOL?

WHAT DOES YOUR CHILD APPEAR TO ENGOY DOING?

HOW DOES YOUR CHILD APPEAR TO SLEEP AT NIGHT (nature and how long)?

PLEASE CHARACTERIZE THE NATURE OF RELATIONSHIPS BETWEEN FAMILY MEMBERS

ARE THERE ISSUES IMPACTING OTHER FAMILY MEMBERS OR THE FAMILY AS A WHOLE? DESCRIBE

ADDITIONAL INFORMATION

1.	IS THIS COUNSELING COURT ORDERED?	◯ YES	◯ NO
2.	IS SOCIAL SERVICES INVLOVES?	◯ YES	◯ NO
3.	IS THE SITUATION URGENT?	◯ YES	◯ NO
4.	IS THE CLIENT OR ANYONE IN THE FAMILY CONSIDERING /THREATENING SUICIDE?	◯ YES	◯ NO
5.	IS THERE A HISTORY OF SUICIDE ATTEMTPS?	◯ YES	◯ NO
6.	IS THERE PHYSICAL CONFLICT PRESENT, SUCH AS HITTING, PUSHING,SLAPPING, BLOCKING EXITS PHYSSICAL TRHEATS, OR ANY FEAR OF THESE?	◯ YES	◯ NO
7.	IS THERE OTHER LEGAL INVOLVEMENT?	◯ YES	◯ NO
8.	IS THERE A HISTORY OF PSYCHIATRIC HOSPITALIZATION?	◯ YES	◯ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE PLEASE EXPLAIN:

OTHER PRESENTING INFORMATIOJN:

NAME OF PERSON FILLING OUT FORM _____ RELATIONSHIP TO CHILD _____

INTAKE COMPLETED BY: _____ DATE: _____