Intake Form- Minor

Client Information: Date: _____

Client Name(s) _____ Birth Date: _____

Grade: _____ Name of School: _____

Family Information:

Parent(s) _____

Parents' Occupations (M)_____ (F) _____

Current Employers (M) _____ (F) _____

Parent's relationship status: Please circle

Married Single Divorced Separated Widowed Living Together Never Married

****Please note****

If parents are divorced we must have a current decree on file before counseling begins

Siblings/ages

1. _____ Age ____ 3. _____ Age ____

2. _____ Age ____ 4. _____ Age ____

More _____

Current Living Arrangements:

_____

What is the family's religious preference?

_____

Is the minor currently active in their religion? Y N

Presenting Problem:

Please briefly describe the presenting problem or issue:

Current Stressors:

Please circle all that apply/list additional. Please provide a brief explanation.

family finance health school loss legal issues adjustment trauma peer issues

Symptoms:

If the minor has experienced a change in any of the following, please indicate an increase or a decrease by marking with arrows.

sleep_____ appetite_____ energy_____ motivation_____ concentration_____

work_____ exercise_____ weight _____ anxiety_____ worry_____ stress_____

pleasure_____ anger_____ sadness_____ helplessness_____ depression_____

self-esteem_____ other_____

Please list any additional symptoms the minor has experienced in the last month:

Safety Issues:

Suicidal: Y N N/A Have you ever had any thoughts of suicide? _____

Previous Attempts/Date _____

Plan/Means _____

Homicidal: Y N N/A Risk: High Med Low

Previous Attempts/ Date _____

Plan/ Means _____

Self-Injury: Y N N/A Age Started: _____ Last S-I: _____ Method:_____

Personal History:

Has the minor experienced any emotional abuse? Y N

If Yes, Please describe:

_____

_____

_____

_____

_____

Has the minor ever experienced any sexual abuse? Y N

If Yes, Please describe:

_____

_____

_____

_____

_____

Has the minor ever experienced any physical abuse? Y N

If Yes, Please describe:

_____

_____

_____

_____

_____

If there has been abuse, has this been reported to CPS or the appropriate authorities? Y N

If yes, please provide the case number _____

Drug/Alcohol Exposure History: (includes use of marijuana and household chemicals)

Chemical	Amount	Frequency / Age Started	Last Usage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History:

Date of last physical exam: _____

Results_____

_____

_____

_____

Any known Diagnoses? Y N List:

_____

_____

Any head injuries? Y N

If Yes, what type?_____ Date _____

Current Medications	Purpose	Date Started	Last Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Psychiatric/Counseling Treatment History

Current/ Previous Therapist, Psychiatrist _____

_____

Reason_____Dates_____

Has the minor been hospitalized for a psychiatric reason? Y N

If yes, please explain:

_____

_____

Any Testing (psychological / neurological)? Y N

Test_____

Results_____

Any Known Psychiatric Diagnosis? Y N

If yes, please explain:

_____

_____

Birth History:

Prenatal Care: Y N

Pregnancy Complications:

_____

_____

Type of Delivery: Natural C-Section

Delivery Complications:

_____

_____

_____

_____

What do you want to accomplish through counseling?

Is there anything else you want your counselor to know?