Client Name: ________________________________

Minor Intake Information Sheet (Ages Infant - 19)

Date _____/_____/_____

Referral Source: Friend/ Physician/ School/ Internet/Other

Minor's Name ____
Last Middle I. First

D.O.B. _____/_____/________ Age ______ Contact Email: ____________________________

Address ____

____

City ________________________ State _____ Zip _____________

Phone: Home __________________ Cell ____________________

This minor/child is in the legal custody of ____

Child is: Natural child of parents ____ Adopted ____ Foster Child ____ Other Relative ____

To be completed by parent or guardian of child seeking counseling

Is child living with both parents? **Y or N** Are parents separated/divorced? **Y or N**

If divorced, do parents have joint custody? **Y or N** Is there a mandated Parenting Plan? **Y or N**

Parent/Guardian bringing in minor child ____

Occupation _____________________________________ Education _____________________

Age ______ Contact Email: ______________________________ Cell _____________________

Address if different from above ____

____

City ______________________________ State _____ Zip ___________

Other Parent/Guardian of Minor Child ____

Occupation _____________________________________ Education _____________________

Age ______ Contact Email: ______________________________ Cell _____________________

Address if different from above ____

____

City ______________________________ State _____ Zip ___________

Client Name: ___________________________________

Persons residing in your household:

Name | Age | Relationship to person seeking counseling

____

____

____

____

____

Current medications:

Type | Dosage | Reason for Taking | Prescribing Physician

____

____

____

____

Current Physician ________________________________ Phone _______________________

List use of Previous Counseling or Psychiatric Services (Outpatient or Inpatient)

____

____

____

Has any other member of the family been treated for Psychiatric or Mental Health concerns ?

____

____

Has any member of the family been treated for medical diseases? _______________________

____

Child's weight at birth _______ lbs. ______oz. Full term birth **Y or N** If no explain _____________

____

Alcohol or drug usage at the time of conception **Y or N**

Client Name: ______________________________

During preschool/toddler years your child's temperament could be described as ________________

____

Place a check by any behavior that applies:

___Did not enjoy being held	___Feeding problems	___Sleep Problems
___Restlessness	___Head-banging	___Sensitive to light/touch/noise
___Colic	___Fussy	___Difficulty Bonding

At what age (year or months) did your child

_____ Sit up alone _____ Walk _____ Begin to words together ____ Toilet Train

Did you note any unusual behavior or speech patterns for your child in the preschool/toddler years or currently?

____

____

What are your concerns for your child?

____

____

____

____

Check if a current concern/Stressor

__ Depressed Mood	__ Sleep Disturbance	__ Apathy	__ Guilt
__ Decreased Energy	__ Poor concentration	__ Appetite Disturbance	
__ Helplessness	__ Worthlessness	__ Anxiety	__ Panic Attacks
__Obsessions/Compulsions	__ Emotionally withdrawn	__ Moodiness	__ Hyperactivity
__Impaired Judgement	__ Impulsiveness	__ Grandiosity	__ Easily distracted
__ Fearful	__ Irritable	__ Anger	__ Delusions
__ Paranoia	__ Hallucinations	__ Agitated	__ Memory Loss
__ Confusion	__ Delirium	__ Binging	__ Purging
__ Weight Change	__ Somatic Complaints	__ Grief	__ Defiance
__ Physical Fighting	__ Learning Challenges	__ Marital Conflict	__ Family Conflict
__ Drug Usage	__ Alcohol Usage	__Financial Concerns	__ Parenting
__ Employment	__ Peer Relationships	__ Frequent Moves	__ School
__ Change of Households			

Client Name: ___________________________________

Received services from DHR? **Y or N** Caseworker's Name ___________________________________

Arrested? **Y or N** Have a Probation Officer? **Y or N** Name ___________________________________

Jailed? **Y or N** Victim Child physical or sexual abuse? **Y or N**

Has anyone in the family been reported to DHR? **Y or N**

Has this child ever been assessed for Learning Challenges or received special educational services?

Y or N If yes at what age (s) ? ____________________ Ever Expelled or Suspended? **Y or N**

Current School ____

Current Teacher ______________________________ Grades for last term ____________________

List Previous Schools including daycare or preschool

School	Age	Grade

Any problems noted in school? ____

____

What do you want your child to accomplish in counseling?

____

____

____

Any other relevant information related to your current concerns for your child:

____

____

____

____

____

Please bring a copy of any custody papers to the initial appointment. Thank you.