INTAKE SHEET FOR MINORS

Who referred you to our center? _____
May we contact them? ____ Yes ____ No

MINOR'S INFORMATION

Primary Client _____
Last Name First Name MI Nickname

Date of Birth _____ Age _____ Gender _____

Address _____
Street City State Zip

Minor's contact phone number (if applicable):_____

May I leave messages on this phone? ___Yes ___ No
May I send text messages to this phone? ___Yes ___ No

Minor's Email (if applicable) _____

PARENT/GUARDIAN INFORMATION

_____
Name Relationship

Date of Birth _____ Age _____ Occupation _____Hours/Week _____

Contact phone:_____
May we leave messages on this phone? ____Yes ____No
May I send text messages to this phone? ___Yes ___ No
Email _____

_____
Name Relationship

Date of Birth _____ Age _____ Occupation _____Hours/Week _____

Contact phone:_____
May we leave messages on this phone? ____Yes ____No
May I send text messages to this phone? ___Yes ___ No
Email _____

FAMILY INFORMATION

Parents' Current Marital Status (if need to differentiate, then please put an F for Father and M for Mother):
___ Never Married ___ Married ___ Divorced___ Separated ___ Widowed ___ Remarried

Date of Marriage (if applicable) _____

Date of Divorce (if applicable) _____ Date of Death (if applicable) _____

Parents' Education Level (please put an F for Father and M for Mother):
_____ GED _____ High School Diploma _____ College Degree _____ Graduate Degree

Name of other family members (Please indicate which members reside with client)
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
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_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____
_____ Age ____ Gender ____ Relationship _____

Please list a history of mental health issues in parents and family members: _____
_____
_____
_____
_____

PERSONAL INFORMATION (to be filled out by parent or guardian)

How would you rate your child/adolescent's health? _____
How many hours do they sleep each night? _____
How would you rate their diet?
___ Very Healthy ___ Healthy ___ Average ___ Needs Improvement ___ Poor
Do they have any addictive issues? ____ Yes ____ No
If so, with what? _____
Has their appetite or weight changed lately? _____

Has your child/adolescent ever experienced mental, physical, emotion, or sexual abuse or neglect? _____ Yes _____No
If, yes, please describe: _____
_____
_____
_____

How have these issues been addressed?_____
_____
_____

Is your child/adolescent adopted? ____ Yes ____ No
If Yes, at what age?_____
Is your child/adolescent currently on medication? ____ Yes ____ No
If so, please complete the following:

Medication	Dosage	Physician	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____ _____ _____

Does your child/adolescent currently attend church? ____ Yes ____ No
If yes, what is the name of the church? _____
Would you like spiritual matters to be part of their counseling? ____ Yes ____ N

PERSONAL CONCERNS

Briefly explain why your child/adolescent is coming to counseling and what you hope for them to gain from their experience. _____

What efforts have you or they already made to address this matter? _____

Has your child/adolescent been in counseling before? ____ Yes ____ No
If so, for each incidence you remember, please complete the following:

1. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

2. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

3. Who was the counselor? _____
   What was the problem? _____
   How many sessions over what period of time? _____
   What were the results? _____

THOUGHTS AND BEHAVIORS

How often do you have the following thoughts? (to be filled out by child/adolescent)

1. Life is hopeless.	____ Never	____ Rarely	____ Sometimes	____ Frequently
2. I am lonely.	____ Never	____ Rarely	____ Sometimes	____ Frequently
3. No one cares about me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
4. I am a failure.	____ Never	____ Rarely	____ Sometimes	____ Frequently
5. Most people don't like me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
6. I want to die.	____ Never	____ Rarely	____ Sometimes	____ Frequently
7. I want to hurt someone.	____ Never	____ Rarely	____ Sometimes	____ Frequently
8. I am so stupid.	____ Never	____ Rarely	____ Sometimes	____ Frequently
9. I am going crazy.	____ Never	____ Rarely	____ Sometimes	____ Frequently
10. I can't concentrate.	____ Never	____ Rarely	____ Sometimes	____ Frequently
11. I am so depressed.	____ Never	____ Rarely	____ Sometimes	____ Frequently
12. God is disappointed in me.	____ Never	____ Rarely	____ Sometimes	____ Frequently
13. I can't be forgiven.	____ Never	____ Rarely	____ Sometimes	____ Frequently
14. Why am I so different?	____ Never	____ Rarely	____ Sometimes	____ Frequently
15. I can't do anything right.	____ Never	____ Rarely	____ Sometimes	____ Frequently
16. People hear my thoughts.	____ Never	____ Rarely	____ Sometimes	____ Frequently
17. I have no emotions.	____ Never	____ Rarely	____ Sometimes	____ Frequently
18. Someone is watching me.	____ Never	____ Rarely	____ Sometimes	____ Frequently

19. I hear voices in my head. ____ Never ____ Rarely ____ Sometimes ____ Frequently
20. I am out of control. ____ Never ____ Rarely ____ Sometimes ____ Frequently

Please rate the following symptoms on a scale of 0-2:

0 = Not significant/Non-existent 1 = Moderate/Sometimes 2 = Frequent/Severe

Excessive anger, easily frustrated	____	Hyperactivity	____
Mood swings (depression-manic)	____	Change or loss of friends	____
Excessive guilt or shame	____	Self-mutilation, cutting	____
Loss of energy	____	Eating disorders	____
Loss of interest in activities	____	Excessive stress	____
Suicidal thoughts	____	Anxiety or excessive fears	____
Suicide attempts (how many)	____	Learning disabilities	____
Lying	____	School related problems	____
Manipulation	____	Hallucinations, delusions, thought distortions	____
Poor impulse control	____	Obsessive thoughts &/or compulsive behaviors	____

Please comment (e.g., examples, frequency, duration, effects on them) about each of the above thoughts/behaviors that occur frequently or are a concern to you or them.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

EMERGENCY CONTACT

Whom should we contact in case of emergency?

Name _____
Address _____
Home Phone _____ Cell Phone _____