INTAKE INFORMATION for MINORS

Please give all information that you are willing to give, and leave blank what is not applicable to your situation.

Minor

Today's date_______________

Name____Age__________DOB_______/______/______

Address____ City &Zip___________________

Phone if applicable _______________________________________

School Currently Attending____ Grade__________

Teacher (if elementary)_________________________________ IEP? ____________ 504 Plan? __________

Parental Custody/visitation ____

Primary Physician____ Phone_________________________

Date of and reason for last visit to PCP____

Other provider(s) involved_____________________________________ Phone________________________

By whom were you referred to Jean?____

Parent/ Legal Guardian

Name____Age________DOB______/_____/_____

Relationship to child: ☐ Biological ☐ Adoptive ☐ Step ☐ Foster

Contacts: (home) ☐_________________________ (cell) ☐__________________________________

(e-mail ☐____

Please check the box if you give permission to leave a message at this phone number or email address.

Address (if different)____

Occupation _______________________________Employer____

Schooling completed: ______________________Religion/church_____________________________________

Current relationship status: ☐single ☐engaged ☐separated ☐married ☐divorced ☐widowed ☐serious relationship ☐ live-in partner ☐remarried

Parent/ Legal Guardian

Name____Age________DOB______/_____/_____

Relationship to child: ☐ Biological ☐ Adoptive ☐ Step ☐ Foster

Contacts: (home) ☐_________________________ (cell) ☐__________________________________

(e-mail ☐____

Please check the box if you give permission to leave a message at this phone number or email address.

Address (if different)____

Occupation _______________________________Employer____

Schooling completed: ______________________Religion/church_____________________________________

Current relationship status: ☐single ☐engaged ☐separated ☐married ☐divorced ☐widowed ☐serious relationship ☐ live-in partner ☐remarried

Stepparent/Parent's Partner (if applicable)

Name____ Age_______DOB_____/_____/______

Relationship to child __________________________Contact phone___________________________

Occupation __________________________Employer______________________________________

Stepparent/Parent's Partner (if applicable)

Name____ Age_______DOB_____/_____/______

Relationship to child __________________________Contact phone___________________________

Occupation __________________________Employer______________________________________

Family

Names of all persons with whom child lives		Age	Gender	Relationship
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

**Please check the box if there are special living/ custody circumstances related to this person.*

Reasons for seeking counseling at this time____

____

____

What have you tried to do thus far to resolve these issues? _____________________________

____

What do you hope to accomplish during therapy? ____________________________________

____

____

Has your child previously seen a counselor? _____________ Dates___________________________

How did it help? ____

____

What diagnoses have other professionals applied to your child? __________________________

____

What medications does your child take? Please state current dosage, reason for use and name of prescriber.

____

____

Has your child taken any mental health medications in the past? If so, what and when. ___________

____

Describe your child's health and any physical symptoms:____

Any allergies? ____

Describe any significant medical history. ____

Was the child exposed to alcohol, nicotine or other drugs during the pregnancy? ______________________

Were there developmental delays in walking, talking, toilet training, etc? ____________________________

How is your child's appetite? ____

How is your child's sleep? ____

Does the child demonstrate sensory sensitivities (lights, sounds, tastes, smells, food textures, touch)?

How would you describe your child's temperament/ personality?

Has your child displayed any significant mood changes? ____

Has the child endured any difficult or traumatic life experiences, including abuse? ________________________

Has the child ever contemplated or attempted suicide? ____

Describe any past or current self-injury (cutting, scratching, pulling out hair, etc)? ________________________

List any citations and arrests. ____

List any issues with alcohol or substance use. ____

Are there immediate or extended family members with alcohol or substance abuse issues? _________________

Are there immediate or extended family members with depression, anxiety, ADHD, Asperger's/autism or other mental health issues? ____

How is your child's academic performance? ____
____

Describe any issues associated with school (learning disabilities, social, behavioral, attendance, etc) ________
____
____
____

How are your child's friendships and peer relationships? ____________________________________
____
____

What are the child's pastimes, hobbies, interests, talents? ___________________________________
____
____

Has the child been adopted? ____________________

By whom has the child primarily been raised? ____

Has the child ever lived away from the parent(s)? ____

How would you describe the atmosphere in your home?
____
____
____

Describe the child's relationships to parents. ____
____
____

Describe the child's relationships to siblings. ____
____
____

What are the current stressors for the child? ____
____
____

What are the strengths, skills and abilities that have helped you and your child?
____
____
____
____

Please indicate your degree of concern with the following issues:

Blank= None 1= Low 2= Moderate 3= High

______	Anger	______	Cannot sit still
______	Clumsy/uncoordinated	______	Communication
______	Critical of others	______	Defiance
______	Demands attention	______	Disinterested, unmotivated
______	Dislikes being touched	______	Disturbing thoughts
______	Eating problems	______	Fascination with fire
______	Fear and worry	______	Fights/aggression
______	Friendships	______	Grief and/or loss
______	Guilt/shame	______	Headaches
______	Hopelessness	______	Impulsivity
______	Irritability	______	Loneliness
______	Low energy	______	Moody
______	Negative toward self	______	Nervous habits
______	Not affectionate	______	Obsessions/compulsions
______	Overly shy	______	Picks at skin
______	Poor attention span	______	Problem-solving
______	Racing thoughts	______	Rel. with extended family
______	Relationships with parents	______	Runs/threatens to run
______	Sadness	______	School- academics
______	School- attendance	______	School- behavior
______	Self-harm, suicidal	______	Sensitive to lights
______	Sensitive to sounds	______	Sexual behaviors/issues
______	Sleep problems	______	Sleeping too much
______	Spirituality	______	Steals
______	Tantrums	______	Tells lies often
______	Too much energy	______	Tries to be perfect
______	Trouble sleeping	______	Tummy/bowel problems
______	Unable to make decisions	______	Unable to relax
______	Uncooperative	______	Victim of abuse
______	Wets or soils self	______	Withdrawn
______	Other: ____________________	______	Other ____________________

Substance Use

Mark "P" for parent in boxes that apply to any parent(s); Mark "M" for minor.

Tobacco (any form) ☐☐current ☐☐past ☐☐never ☐☐occasionally Amount____________

Alcohol ☐☐current ☐☐past ☐☐never ☐☐occasionally Amount____________

Marijuana ☐☐current ☐☐past ☐☐never ☐☐occasionally Amount____________

Street/ Recreational/Non-prescribed Drugs ☐☐current ☐☐past ☐☐never ☐☐occasionally

*This form was completed by*____.