Minor Counseling Intake

PARENT/GUARDIAN INFORMATION

Name: _____ Date: _____

Home address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

For confidentiality, when and where do you prefer to be reached? _____

Marital Status: ☐ S ☐ M ☐ Sep. ☐ D ☐ W Date of Current Marriage/Separation: _____ Number of Marriages: _____

Child(ren)'s Names: _____ Date of Birth: _____ ☐ M ☐ F

_____ Date of Birth: _____ ☐ M ☐ F

_____ Date of Birth: _____ ☐ M ☐ F

Occupation: _____

Name of other custodial parent: _____ Phone: _____

Do you have consent from the other custodial parent for treatment of said child? ☐ Y ☐ N
If no, this will be required by the therapist before counseling may begin.

How much contact does the child have with his/her biological mother/father? _____

Do you believe in God? ☐ Yes ☐ No Religious preference: _____

How much influence does your religion have on your day-to-day activity? _____

Complete all remaining information according to the child coming for treatment.

GENERAL INFORMATION

Name: _____ Date of Birth: _____ ☐ M ☐ F

The child is currently living with: _____

School: _____ Grade: _____

Extracurricular activities/interests: _____

MEDICAL HISTORY

How would you rate your child's current physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is the child complaining of any physical problems? (headaches, stomach aches…) _____

_____

Previous hospitalizations for medical reasons:

Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____

MEDICATION(S) Over-the-counter or prescription	DOSAGE

Please list any learning disabilities:_____

COUNSELING & PSYCHIATRIC HISTORY

Has the child had any previous counseling? ☐ Yes ☐ No If yes, for how long? _____

For what reason?_____ Name/location of counselor:_____

Has the child ever been diagnosed with or treated for any type of mental illness? ☐ Yes ☐ No

If yes, which type? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? ☐ Yes ☐ No

If yes, which type? _____

PSYCHIATRIC MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns about the child have led you to pursue counseling?_____

_____

Where are these concerns causing the most problems for YOU? Check all that apply:

☐ Home ☐ Work ☐ Marriage ☐ Other:_____

Where are these concerns causing the most problems for the CHILD? Check all that apply:

☐ Home ☐ School ☐ Friends ☐ Other:_____

When did the present concerns begin to be a problem for the child?_____

What concerns about the child have been identified by others?_____

Please indicate which of the following areas are currently causing problems for the child. Check all that apply:

- ☐ Crying spells
- ☐ Excessive fears or anxieties
- ☐ Difficulty being away from specific family members
- ☐ Hearing voices
- ☐ Getting into trouble at school/play
- ☐ Temper tantrums
- ☐ Difficulty falling asleep/inability to sleep at night
- ☐ Decreased/increased appetite
- ☐ Loss of interest in usual activities
- ☐ Hyperactivity
- ☐ Bullying/picking fights
- ☐ Refusal to respond to authority
- ☐ Nightmares
- ☐ Obsessions/compulsion with specific activities
- ☐ Lack of motivation
- ☐ Lack of self-confidence
- ☐ Difficulty making or keeping friends
- ☐ Other: _____

EMERGENCY CONTACT

Name:_____ Relationship to child: _____

Home Phone:_____ Work Phone: _____

Address:_____ City, State, Zip: _____

What do you hope to gain from counseling?_____

_____

How did you hear about A New Perspective? ☐Friend ☐Pastor ☐Church ☐Other:_____

Consent for Counseling of Minors

(Age 17 and under)

Name of Parent / Guardian_____

Name of Minor_____

Minor's Date of Birth_____

Name of Counselor_____

Minor Phone Number_____

E-mail_____

This is to certify that I give permission for the minor named above to participate in counseling offered by A New Perspective.

Signature of Parent/Guardian_____ Date_____

Printed Name of Parent/Guardian_____

Street Address_____

City / State / Zip_____

Home Phone_____Work / Cell Phone_____

Emergency Contact (other than yourself)_____Phone_____

Adolescent Counseling Intake

To be filled out by teen (ages 13 - 17)

Name_____ Date of Birth:_____

Address:_____ City, State, Zip:_____

Who are you presently living with?_____

School:_____ Grade:_____

Hobbies:_____

Job (if none, leave blank):_____

Do you believe in God? ☐ Yes ☐ No Religious Preference:_____

What concerns have brought you to counseling today?_____

_____

PROBLEMS CHECKLIST

Please rate each issue with a number:

1=Major Problem 2=Sometimes a Problem 3=Never a Problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Feeling bad about the way I look/my body

_____ Getting along with my parents or other family members

_____ Getting a clear sense of what I value

_____ Worrying about whether I'm normal

_____ Dealing with sexual feelings and/or problems

_____ Excessive worry or anxiety

_____ Trying to decide on a career

_____ Never eating/eating too much and vomiting to control weight

_____ Dealing with my alcohol or drug abuse

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

Are there any other problems or concerns you would like to address?_____

_____