MINOR CLIENT INTAKE FORM DATE:

Please take your time in providing the following information. The questions are designed to help us begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Referred by: ______________________________ Agency: ______________________________

Contact Information: ______________________________ Email: ______________________________

PARENT/LEGAL GUARDIAN

Name: ______________________________ Relationship: ______________________________

Home Phone: ______________________________ Mobile Phone: ______________________________

How did you hear about us? [ ] Internet [ ] Physician [ ] Friend [ ] Parent [ ] Other

Name of person who referred you: ______________________________

May we thank them for referring you? [ ] Yes [ ] No

MINOR GENERAL INFORMATION

Last Name:______________________________First Name:______________________________

Age:______________________________ DOB:______/______/______

Street Address:______________________________

City______________________________State:______________Zip: ______________

Ethnicity: [ ] White [ ] Black [ ] Hispanic [ ] Asian [ ] Other

Gender:
[ ] Male
[ ] Female
[ ] Transgender
[ ] Declined
[ ] Other: ______________________

Preferred Pronoun: ______________

Sexual Orientation:
[ ] Straight
[ ] Lesbian
[ ] Gay
[ ] Bisexual
[ ] Declined
[ ] Other: ______________

Email Address: ______________________________

Phone (H):______________________________May we contact you here? [ ]Yes [ ] No

Phone (C):______________________________May we contact you here? [ ]Yes [ ] No

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Phone (W):____ May we contact you here? [ ]Yes [ ] No

May we leave a message for you? [ ] Yes [ ] No May we text you? [ ]Yes [ ] No

Parent/Guardian Occupation: ______________________ Employer: ________________________________

Parent/Guardian Occupation: ______________________ Employer: ________________________________

EDUCATION:

School: ____Grade Level: ________________________________

Any special accommodations (IEP, 504 plan, etc.): ____

____

RELATIONAL STATUS

Current parent/guardian relational status:

[ ] Single

[ ] Dating

[ ] Domestic Partner (how long?) _________

[ ] Engaged (how long?) _________

[ ] Married (how long?) _________

[ ] Separated (how long?) _________

[ ] Divorced (how long?) _________

[ ] Widowed (how long?) _________

HOUSEHOLD INFORMATION: List everyone residing in your home.

Name	Sex	Age	Relationship (i.e. Natural, Step, Adopted

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RELIGIOUS BACKGROUND

Briefly describe the religious environment of your home as you were growing up: ______________________

____

____

Do you regularly attend a place of worship? [ ] Yes [ ] No If yes, where?____________________

MILITARY

Military experience? [ ] Yes [ ] No Combat experience? [ ] Yes [ ] No

Where: ______________________ Branch: ______________________

Type of discharge: ______________________

Length of service: ______________________

Rank at discharge: ______________________

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past: ______________________

____

____

SUBSTANCE USE

Please check substances you use on a weekly/monthly (circle) basis:

Alcohol:	________ x per week / month	Marijuana:	________ x per week / month
Cocaine:	________ x per week / month	Heroine:	________ x per week / month
Meth:	________ x per week / month	Ecstasy:	________ x per week / month

Check all that apply:

_____ I believe that my substance use may be a problem.
_____ I believe that my partner's substance use may be a problem.

MEDICAL INFORMATION:

Primary Physician: ______________________ Phone: ______________________ Fax: ______________

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City/State: ______________________ Date of your last physical exam? ______________

Describe your current health: [ ] Great [ ] Good [ ] Fair [ ] Poor

Specialty (e.g. Family Practice, OB/GYN, Oncology/Hematology): ______________________

Are you currently receiving medical treatment? [ ] Yes [ ] No

If yes, please specify: ____

List significant conditions, illnesses, surgeries, hospitalizations, traumas, or treatments you've had. (Use back if necessary.)

____

____

____

Height: __________ Weight: ______________
Has your weight changed in the last 2-3 months? Yes No (If so, how): ______________________

____

List all current medications you are taking, including those you seldom use or take only as needed. Also include any over-the-counter herbal medications and/or supplements. (Use back if necessary.)

Medication/Supplement	**Dosage**	**Purpose for Usage**

Are you compliant with your medications and follow up appointments? [ ] Yes [ ] No

Any barriers in being able to meet your own medical needs? [ ] Yes [ ] No

If yes, please describe barriers: ____

PRESENTING ISSUES AND GOALS:

Please describe reason for seeking services (What are the issues or problems of concern?)

____

____

____

____

LEVEL OF DISTRESS:

Indicate how distressed you are by placing a check or "X" on the scale below
(1= Very Little Distress; 10=Extreme Distress):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Are you currently experiencing any suicidal thoughts? [ ] Yes [ ] No

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Have you experienced them in the past? [ ] Yes [ ] No

Have you ever attempted suicide? [ ] Yes [ ] No If yes, when & how? ______________________

____

____

____

Have any of your friends or family ever committed or attempted suicide? [ ] Yes [ ] No

If yes, please explain briefly: ____

CURRENT STATUS:
Please check any of the following physiological symptoms that apply to you presently or in the recent past:

Symptom	Past	Present
Headaches	[ ] Past	[ ] Present
Visual Trouble	[ ] Past	[ ] Present
Weakness	[ ] Past	[ ] Present
Difficulty Breathing	[ ] Past	[ ] Present
Change in Appetite	[ ] Past	[ ] Present
Hearing Voices	[ ] Past	[ ] Present
Dizziness	[ ] Past	[ ] Present
Sleep Trouble	[ ] Past	[ ] Present
Tension	[ ] Past	[ ] Present
Intestinal Trouble	[ ] Past	[ ] Present
Tiredness	[ ] Past	[ ] Present
Seeing Things	[ ] Past	[ ] Present
Stomach Trouble	[ ] Past	[ ] Present
Trouble Relaxing	[ ] Past	[ ] Present
Rapid Heart Rate	[ ] Past	[ ] Present
Hearing Noises	[ ] Past	[ ] Present
Pain	[ ] Past	[ ] Present
Other: ____________	[ ] Past	[ ] Present

Please check any of the following problem areas that may apply:

Stress	[ ]	Recent Loss	[ ]	Being a Parent	[ ]
Panic	[ ]	Nervousness	[ ]	Disaster	[ ]
Guilt	[ ]	Unhappiness	[ ]	Anxiety	[ ]
Recent Death	[ ]	Apathy	[ ]	Depression	[ ]
Inferiority Feelings	[ ]	Grief	[ ]	Terminal Illness	[ ]
Shyness	[ ]	Defective Feelings	[ ]	Hopelessness	[ ]
School Problems	[ ]	Fears	[ ]	Loneliness	[ ]
Emotional Abuse	[ ]	Communication	[ ]	Friends	[ ]
Temper	[ ]	Verbal Abuse	[ ]	Physical Abuse	[ ]
Bad Dreams	[ ]	Anger	[ ]	Sexual Abuse	[ ]
Unwanted Thoughts	[ ]	Concentration	[ ]	Aggressiveness	[ ]
Impulsive Behavior	[ ]	Memory	[ ]	Racing Thoughts	[ ]
Sexual Problems	[ ]	Self-Control	[ ]	Loss of Control	[ ]
Legal Matters	[ ]	Pregnancy	[ ]	Compulsivity	[ ]
Drug Use	[ ]	Trauma	[ ]	Abortion	[ ]
Career Choices	[ ]	Alcohol Use	[ ]	Eating Problems	[ ]
Confidence	[ ]	Ambition	[ ]	Trouble with Job	[ ]

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Making Decisions [ ] Finances [ ] Other : ________________[ ]

PREVIOUS COUNSELING:

List any previous counseling, psychiatric treatment, or residential/in-patient care you have received. (Use back if necessary.)

THERAPIST	LOCATION	DATES	REASON

FUNDING SOURCE

[ ] SELF PAY [ ] INSURANCE MEDICAID [ ] INSURANCE COMMERCIAL [ ] OTHER

POLICY NAME: ______________________________ POLICY NUMBER: ___________________________________

GROUP NUMBER: ___________________________ INSURANCE PHONE #: ______________________________

CLAIM ADDRESS: ____

CITY: _______________________________ STATE: _______________ ZIP: __________________

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24-hour notice of intention to cancel, I will be charged the full administrative fee for service.

PRINT NAME: ____DATE:_______________

SIGNATURE (*LEGAL GUARDIAN IF UNDER 18*):____

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the release of any medical/psychiatric information acquired in the course of my examination/treatment to my health and hospital insurance companies to facilitate payment for services rendered.

PRINT NAME: ____DATE:_______________

SIGNATURE (*LEGAL GUARDIAN IF UNDER 18*):____