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?__________________

____