



Confidential Minor Intake

Date _____

Referred By _____

Payment Information - Insurance Y N Carrier _____ Cash Pay _____

Minor's Last Name _____ First Name _____ Middle Initial _____ Birth Date _____

Address _____ City _____ Zip _____

Home Phone: _____ Social Security # _____

Father's Name: _____

Father's Employer: _____ Work Number: _____

Mother's Name: _____

Mother's Employer: _____ Work Number: _____

If needed, may we contact you at work? Yes No

Marital Status of parents (circle one) Married Single Divorced Separated Deceased

If parents are separated or divorced, parent child is currently living with and custody arrangements:

Siblings's Names (include step)	Birth Date	Address (if different)
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Additional Comments on Children or Parents Marital History: _____ _____ _____ _____
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Current School: _____ Teacher/ School Counselor: _____

Current Grade: _____ Current Grade Average: _____

School History: School/Grade/Age/Dates _____ _____ _____ _____

Church Affiliation (if any) _____ Name of Pastor/Rabi/Priest _____



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Is minor currently under medical treatment? Yes ___ No ___ If yes, name of Doctor: _____

Is minor currently taking any medication? Yes ___ No ___ If yes, please list: _____

Please describe any current or chronic diagnosed medical conditions: _____

Is minor currently involved in any legal matters, including custody disputes or insurance settlements? If so, please describe: _____

Previous counseling experiences

Counselor _____ Length of Counseling _____
 Dates _____ Location _____

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 Dates _____ Location _____

Reason for seeking counseling: (Describe presenting problem, including length & precipitating event, if applicable)

Goals for counseling:

Please circle any appropriate answers:

- | | |
|---|--------------------------------|
| 1. Current or previous alcohol or drug abuse | 8. Changes in sleep |
| 2. Eating disorders | 9. Changes in level of energy |
| 3. Family current or previous alcohol or drug abuse | 10. Changes in eating habits |
| 4. Habits minor is struggling with _____ | 11. Behavior problems |
| 5. Anger difficulty | 12. Parents arguing frequently |
| 6. History of sexual abuse | 13. Recent move |
| 7. History of physical abuse | 14. Recent loss of a loved one |
| | 15. School difficulties |
| | 16. Anxiety difficulties |



To your knowledge, has the minor ever had suicidal thoughts? (Please circle) Yes, Current Yes, Past None

If yes, please explain

Give a brief description of child's life stressors from ages 1 to 3:

Give a brief history of relationships with:

Father _____

Mother _____

Brother(s)/Sister(s) _____

Spouse _____

Children _____

Are there additional comments you would like to tell us about the minor?

Individual providing minor's information:

Printed Name

Signature