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MINOR INTAKE FORM

Name of Child/Adolescent: ___________________ Date of 1st Appt.: _________________

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Who referred client? _____________________ Why did they refer client? ____

Why did you choose Vickie Purdy, LPC over other therapists in this area?

____

What would you like to see happen as a result of counseling? ____

____

Did something happen to prompt you to seek help now, versus when the problem first began? ______________________

____

Is there pending / expected court involvement: custody, placement, parental rights, CPS? ☐Y ☐N

Is the client seeking disability due to their current mental/emotional health? ☐Y ☐N

Is the client seeking counseling due to a court order or criminal charges? ☐Y ☐N

Client Information

Last Name__________________________ First Name___________________________ Middle Initial____

Birth Date______ /______ /__________ Social Security Number________-______-_________

Street Address____Apt #________

City__________________________ State______ Zip___________ Home phone ______________________

Parent/Guardian's Cell phone_________________________ Email ________________________________

May we: ☐Call ☐Leave a message ☐Text ☐None Prefer: ☐Cell ☐Home

Gender	**Sexual Orientation**	**Do you identify as Transgender?**
☐Male	☐Straight/Heterosexual	☐Yes
☐Female	☐Gay, Lesbian, or Queer	☐No
☐Non-binary/3	☐Bisexual	☐Prefer not to say
☐Prefer to self-describe _______________________	☐Prefer to self-describe _______________________	
☐Prefer not to say	☐Prefer not to say	

Racial/Ethnic identity: ☐African American ☐Asian American ☐Hispanic/Latino ☐Native American

☐Pacific Islander ☐White/Caucasian ☐Other

Emergency Contact: Name_______________________________ Contact number: _______________________

Relationship to the client: _______________________________

Education: Current grade____________ School____________________________ Problems at school? ☐Y ☐N

If yes, please explain: ____

____

What services does child receive from school? ____

Employment: ☐Full-Time ☐Part-Time ☐Student

Employer: ____

What type of work do you do? ____

Family:

Parents: ☐Married ☐Cohabitating ☐Never Married ☐Separated ☐Divorced

Mother ________________________ ☐Full Custody ☐Joint Custody ☐No Rights ☐Other

Father: _________________________ ☐Full Custody ☐Joint Custody ☐No Rights ☐Other

If other, please explain: ____

Is there a legal document outlining custody? ☐Y ☐N (**copy required prior to client being seen**)

Is the minor in the care of a guardian or conservator? ☐Y ☐N If yes, who?______________________________

What is this person's relationship to the child? ____

Is there a legal document detailing this? ☐Y ☐N (**copy required prior to client being seen**)

Siblings: How many? ____ I am the: ☐Oldest ☐In the Middle ☐Youngest ☐Only Child

Siblings' Names & Ages: ____
List everyone living in the home with the client (name & relationship):

____

____

____

What are the most significant events in client's life? ____

____

Has the client or anyone in the client's family experienced abuse or neglect? ☐ Yes ☐ No

Is the client currently experiencing abuse or neglect? ☐ Yes ☐ No

Is there a history of CPS involvement? ☐ Yes ☐ No If yes, please explain: ______________________________

____

Religion/Denominational preference____________________ Congregation (if any): _________________________________

Check all that the client is experiencing (within the past two months):

☐ Thoughts of suicide	☐ Anxiety	☐ Rage
☐ Thoughts of death	☐ Excessive worry	☐ Anger
☐ Plans to harm self	☐ Panic Attacks	☐ Irritability
☐ Thoughts of harming others	☐ Chronic fear	☐ Relationship to significant other
☐ Plans to harm others	☐ Irrational fears	☐ Relationship to parents
☐ Self-injury	☐ Problems due to abuse/trauma	☐ Relationship to children
☐ Loss of meaning in life	☐ Stress	☐ Sexual problems
☐ Loss of hope	☐ Obsessions	☐ Sexual orientation
☐ Depression	☐ compulsions	☐ Gender identity issues
☐ Decreased pleasure	☐ Phobias	☐ Conflicts at work
☐ Lack of activities	☐ Feel like I'm losing control	☐ Problems in school
	☐ Restlessness	☐ Loss of faith in God
☐ Isolating/withdrawn	☐ Muscle tension	☐ Religious doubts
☐ Decreased energy/fatigue	☐ Problems with sleep	☐ Substance use problems
☐ Change in appetite	☐ Problems with concentration	☐ Hallucinations
☐ Significant weight change	☐ Problems with memory	☐ Delusions
☐ Feelings of worthlessness	☐ Avoid open spaces	☐ Easily distracted
☐ Grief	☐ Behavioral problems	☐ Other/Explain below
☐ Loneliness	☐ ADHD	
☐ Guilt feelings		

Looking over this list of problems, please circle those that are causing you the most difficulty right now.

List some therapeutic goals you (as parent/guardian) hope your child/teen will achieve through counseling:

____

____

If child is 12 or older, what do you hope to accomplish or work to improve through counseling?

____

Mental Health

Has the client experienced mental health problems before? ☐ Yes ☐ No

If yes, please explain: ____

Does the client have a family history of mental health problems? ☐ Yes ☐ No

Has the client ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues? ☐Y ☐N

If yes, please give name of therapist or agency? ____

For what reason? ____

When and where? ____

Has the client ever been hospitalized or received inpatient treatment for mental health issues? ☐Y ☐N

If yes, when and where? ____

Reason for treatment? ____

Self-Harm:

Has the client ever engaged in self-injury (SI) behaviors, such as cutting or self-mutilation? ☐Y ☐N

When did client begin engaging in SI? __________ How often? _________________When was the last time?__________

Has the client ever attempted suicide? ☐ Yes ☐ No

If yes, number of attempts: ________________ When? ____

Has the client ever lost someone they care about to suicide? ☐ Y ☐ N

If yes, who and when? ____

<u>Substance Use History:</u>

Alcohol Use: Does the client drink alcohol? ☐ Y ☐ N

On average, how many drinks does client have per week? _________

Amount and type of alcohol consumed: ____________ How many drinks in one day? _______________

Do client ever drink alone? ☐Y ☐N Does client typically drink to feel a buzz/get drunk? ☐Y ☐N

Has client ever had problems, or gotten into trouble (legal, or otherwise) because of drinking alcohol? ☐Y ☐N

Describe what happened: ____

____

Drug Use:

Does the client use drugs (illegal drugs, recreational drugs, drugs not prescribed to client, or used in amts. or in ways other than as prescribed)? ☐ Y ☐ N List all types of substances client has used (including amt/frequency/etc.)

Type used: ______________________________ Amt. taken: ______________ per day/week/month _________________

Age of first use: ________________________________ Last time substance was used: _____________________________

Type used: ______________________________ Amt. taken: ______________ per day/week/month _________________

Age of first use: ________________________________ Last time substance was used: _____________________________

Type used: ______________________________ Amt. taken: ______________ per day/week/month _________________

Age of first use: ________________________________ Last time substance was used: _____________________________

(If additional room is needed to describe substance usage, please continue on the back of this form.)

Has the client ever received outpatient treatment (counseling, therapy, psychiatrist, medication) for a drug or alcohol problem? ☐Y ☐N

If yes, by whom, when and where? ____

Completed treatment successfully? ☐Y ☐N

Has the client ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem? ☐Y ☐N

If yes, when and where? ____

Completed successfully? ☐Y ☐N

Medical History of Client

Pediatrician___________________________ Date of last medical examination? __________________________________

List any physical illness or symptoms the client is having at this time: ____

List major surgeries or illnesses: ____
List current medications (include dosages and physician prescribing):

____

ⓘ **Custody or guardianship paperwork is required (if applicable) prior to a minor client being seen for services.**

Acknowledgement: The information written on this form is accurate, to the best of my knowledge.

______________________________/____/____________________
Signature of Parent / Guardian Signature of Adolescent Client Date