

INTAKE FORM FOR MINOR CHILD (UNDER 15 Years Old)

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better your counselor will be able to assess your minor child's mental health needs. Please provide as much information as possible.

This intake form should be filled out by the Parent(s) or Legal Guardian(s) consenting to mental health services for the minor child listed below. For purposes of mental health treatment in Colorado, a minor child is everyone that is under the age of fifteen (15) years old. The counselor may interview the child and fill out the applicable sections or may request that the parent(s) or legal guardian(s) fill out the applicable section about their minor child. This is within the sole discretion of your counselor.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Minor Child Client Information:

Client's Name: _____

Gender: Male Female

Client's Birthdate: _____

Client's Address: _____

City: _____ State: _____ Zip Code: _____

Parent(s) or Legal Guardian(s) Information:

Are the child's parents: Married or Civil Union Separated Divorced Living Together
If the child's parents are no longer together, are either of the child's parents remarried:

YES NO

Please list any Stepmother and/or Stepfather's Names and telephone numbers:

May your counselor contact any Stepmother and/or Stepfather: YES NO

Mother's Name: _____

Mother's Telephone: _____

Mother's Address: _____

Mother's Occupation: _____

Does the child live with his/her Mother: YES NO

If yes, does the child live with her: Full-Time Part-Time

May your counselor contact mother: YES NO

Father's Name: _____

Father's Telephone: _____

Father's Address: _____

Father's Occupation: _____

Does the child live with his/her Father: YES NO

If yes, does the child live with him: Full-Time Part-Time

May your counselor contact father: YES NO

If the minor child's parents are divorced and/or a custody agreement is in place, please state which parent/legal guardian has decision-making authority and custody of the minor child:

If the minor child's parents or legal guardians are not married or are legally separated, please provide the court custody order or custody agreement that states who has decision-making authority and custody of the minor child. **your counselor cannot provide any mental health services until a custody order or custody agreement is provided. It is also beyond the scope of your counselor's practice to provide custody recommendations.**

Contact Information for Consenting Parent/Legal Guardian:

Address: _____

May your counselor contact you at this address: YES NO

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May your counselor contact you at all the above telephone numbers provided: YES NO

May your counselor leave a voice message at all the above telephone numbers provided: YES

NO

Email Address: _____ Do you share this email address with anyone else?

YES NO

If so, please list who else shares the email address: _____

May your counselor contact you at the above email address: YES NO

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing your counselor to contact you by email you are consenting to receive electronic communications and understand the risks involved. your counselor cannot guarantee that confidential information shared using electronic communications will remain confidential.**

What is your preferred method of communication:

Telephone (H) Cell Phone, including texts Telephone (W) Email

Family Information:

Do you have any other children: YES NO

Please list their names and birthdates on the spaces provided below

Do your other children live with you: YES NO

If no, who do your other children live with:

Are there any other persons that live in your home with you: YES NO

If yes, please list their names and birthdates, and relation to you and/or the child:

Emergency Contact Information:

In case of an emergency, your counselor may be required to contact someone on your behalf. Please list your emergency contact below, which your counselor may contact on your behalf. your counselor will share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: _____

Telephone Number: _____

Relationship to Client: _____

Primary Care Physician Information:

In order to provide your minor child with continuous and congruent care, your counselor may need to contact your child's primary care physician. Any contact that your counselor may have with your child's Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please Provide the Date of Your Child's Last Physical: _____

May your counselor contact your child's physician: YES NO

Please list any medication your minor child is currently taking (if your minor child is not currently taking any medication(s), please state so):

Please list any current physical illnesses, issues, and/or ailments your minor child has (if your minor child does not currently have any physical illnesses, issues, and/or ailments, please state so):

Previous/Current Mental Health Provider(s):

In order to provide your minor child with continuous and congruent care, your counselor may need to contact your minor child's previous or current Mental Health Provider. Any contact that your counselor may have with your minor child's previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please Provide the Date of Your Minor Child's Last Session: _____

May your counselor contact your minor child's previous or current Mental Health Provider:

YES NO

Is your minor child currently in counseling with the above listed mental health provider:

YES NO

Have you ever sought counseling for your minor child before: YES NO

If yes, please list your reason(s) for seeking mental health services for your minor child (if your minor child is currently seeing another mental health provider, please list the reason(s) here as well):

Minor Child Client's Mental Health:

Please tell us why you are seeking counseling for your minor child and describe any issues/problems that led you to seek counseling.

How have you or your minor child dealt with these issues/problems in the past:

Please list any past or current psychological illnesses or other mental health issues your minor child has or other issues that you have sensed may/have affect your minor child:

Has your minor child ever been, or is currently, suicidal:

Has your minor child ever attempted to commit suicide:

Has anyone in your family ever attempted or committed suicide:

Have you or your minor child used, or currently use alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones and how often):

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate): YES NO

Has your minor child ever tried to hurt himself/herself before? If so, please describe the circumstances and what happened:

Has your minor child ever gotten in trouble at school? If so, please describe the circumstances and what happened afterwards:

Are you currently involved in any civil or criminal legal proceedings: YES NO

If yes, please state the reason(s):

Are there any weapons available or unlocked in your home:

YES NO Prefer not to Answer

If yes, please list the weapon, where it is located, and who it belongs to:

Does your minor child have a preoccupation with weapons, violence, killing, or fire:

YES NO Prefer not to Answer

If yes, please describe:

Minor Child Client's Hobbies and Interests:

Does your child play any sports or musical instruments: YES NO

If yes, please list what sports and/or musical instruments he/she plays:

Please list any other hobbies or interests that your minor child has:

How does your minor child normally spend his/her day? What does a typical day look like for him/her?

What school does your child attend and what grade is your child in:

Does your child participate in a religious community? Which one? With whom?

What is your child's favorite subject taught in school:

Please describe your child's strengths, weaknesses, general behavior, and attitude:

Is there anything else you would like your counselor to know:

What would you like to accomplish through therapy and/or any goals you would like your minor child to achieve?:

Are there any restraining orders that your counselor should be aware of: YES NO

If yes, please provide a copy of the restraining order and describe the circumstances under which it was ordered):

Who will be dropping off and picking up the minor child at your counselor's office:

*Does your counselor have permission to discuss administrative details, such as appointments and scheduling with this person: YES NO

A separate Authorization for Release of Information will be required to discuss any details with the above named individual.

Is there anyone that should **NOT** pick up the minor child from the counseling office:

Financial Information (Please have the Parent or Legal Guardian Fill out this Portion):

1. Do you intend on a third-party (besides an insurance company) paying for counseling services:

YES NO

If yes, please provide the following information:

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Relationship to Client: _____

3. Do you intend on paying for counseling services for your minor child on your own:

YES NO

INTAKE FORM FOR MINOR CHILD (UNDER 15 Years Old) SIGNATURE PAGE

Parent or Legal Guardian Affirmation:

By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

Parent/Legal Guardian Signature

Date

Relationship to Client

Client Name

Checklist Of Concerns:

Client Name: _____

Please mark all of the areas of concern below that apply to your minor child or that you have for your minor child. You may add a note or details in the space next to the concerns checked.

| CONCERN | NOTES | NOW | IN THE PAST |
|--|-------|-----|-------------|
| Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals | | | |
| Aggression, violence | | | |
| Alcohol use | | | |
| Anger, hostility, arguing, irritability | | | |
| Anxiety, nervousness | | | |
| Attention, concentration, distractibility | | | |
| Childhood issues | | | |
| Codependence | | | |
| Confusion | | | |
| Compulsions | | | |
| Decision-making, indecision, mixed feelings, putting off decisions | | | |
| Delusions (false ideas) | | | |
| Dependence | | | |
| Depression, low mood, sadness, crying | | | |
| Divorce, separation | | | |
| Drug use—prescription medications, over-the-counter medications, street drugs | | | |
| Eating problems—overeating, undereating, appetite, vomiting, (see also “Weight and diet issues”) | | | |
| Emptiness | | | |
| Failure | | | |
| Fatigue, tiredness, low energy | | | |
| Fears, phobias | | | |

| | | | |
|--|--|--|--|
| Friendships | | | |
| Grieving, mourning, deaths, losses, divorce | | | |
| Guilt/Shame | | | |
| Headaches, other kinds of pains | | | |
| Health, illness, medical concerns, physical problems | | | |
| Inferiority feelings | | | |
| Interpersonal conflicts | | | |
| Impulsiveness, loss of control, outbursts | | | |
| Irresponsibility | | | |
| Judgment problems, risk taking | | | |
| Legal matters, charges, suits | | | |
| Loneliness | | | |
| Memory problems | | | |
| Menstrual problems, PMS, menopause | | | |
| Mood swings | | | |
| Motivation, laziness | | | |
| Nervousness, tension | | | |
| Obsessions, compulsions (thoughts or actions that repeat themselves) | | | |
| Oversensitivity to rejection | | | |
| Pain, chronic | | | |
| Panic or anxiety attacks | | | |
| Perfectionism | | | |
| Pessimism | | | |
| Procrastination, laziness | | | |
| Relationship problems (with friends, with relatives, or at work) | | | |
| School problems | | | |
| Self-centeredness | | | |

| | | | |
|--|--|--|--|
| Self-esteem | | | |
| Self-neglect, poor self-care | | | |
| Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse") | | | |
| Shyness, oversensitivity to criticism | | | |
| Sleep problems—too much, too little, insomnia, nightmares | | | |
| Smoking and tobacco use | | | |
| Spiritual, religious, moral, ethical issues | | | |
| Stress, relaxation, stress management, stress disorders, tension | | | |
| Suspiciousness, distrust | | | |
| Suicidal thoughts (Your child or a relative) | | | |
| Temper problems, self-control, low frustration tolerance | | | |
| Thought disorganization and confusion | | | |
| Threats, violence | | | |
| Weight and diet issues | | | |
| Withdrawal, isolating | | | |

Other concerns or issues:

CHECKLIST OF CONCERNS SIGNATURE PAGE

Parent or Legal Guardian Affirmation:

By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

Parent/Legal Guardian Signature

Date

Relationship to Client

Client Name