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Client Intake Form – Child/Adolescent

Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.

CLIENT INFORMATION

Name _____ Preferred Name_____

Date of Birth _____ Age _____

Sex _____ Gender/Preferred Pronouns _____

Address _____

Parent / Legal Guardian (If under 18) _____

Parent / Legal Guardian (If under 18) _____

Parent Contact Phone Number _____

Parent Contact E-Mail Address _____

Client Contact Phone Number _____

Contact E-Mail Address _____

Ethnicity _____ Religion _____

Emergency Contact Information

EMERGENCY CONTACT NAME _____

* Please note, as stated in the "Safety" section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

SCHOOL INFORMATION

School Name _____

Grade _____ ☐ 504 Plan? ☐ IEP? ☐ Other Special Services? _____

Extra Curricular Activities/Hobbies/Sports?_____

Do you enjoy school? YES NO SOMETIMES

Best part? _____

Worst part? _____

Goals/hopes after High School? _____

Client Health History

Name of primary care doctor: _____ Phone: _____
Last check-up was during the month of: _____ Year: _____
Results: _____
_____

Name of Psychiatrist: _____ Phone: _____
Last visit was during the month of: _____ Year: _____
Results: _____
_____

Would you like me to coordinate with current providers? ☐ Yes ☐ No

Have you been diagnosed with any physical health problems?

_____

Any significant allergies?_____

Mental Health History

Previous Mental Health diagnosis: _____

History of alcohol / drug use? ☐Yes ☐No Describe: _____

Has the client ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No

If yes, when? _____

Has the client ever made a plan to commit suicide or attempted suicide?

☐ Yes ☐ No If yes, when? _____

Does the client currently have thoughts of ending their life? ☐ Yes ☐ No

History of Mental Health Services - list age(s) & provider:

History of Psychiatric medication ☐ Yes ☐ No

List:

Please list additional information you would like me to know:

_____

_____

_____

Current Mental Health

Current Medications: _____

Please check following symptoms or issues that apply to the client:

☐ Anxiety	☐ Depression	☐ Behavior at home
☐ Stress	☐ Sexuality	☐ Behavior at school
☐ Drug/Alcohol Use	☐ Anger	☐ Worry/Fear
☐ Self-esteem	☐ Abuse	☐ Strained relationship(s)
☐ Sleep Changes	☐ Cutting/Self-Harm	☐ Suicidal Thoughts
☐ Health Concern	☐ Life Change	☐ Grief and Loss
☐ Disordered Eating	☐ Trauma	☐ Decision Making/self control
☐ Focus/Attention	☐ Lack of motivation	☐ Divorce/Separation

How intense is your emotional distress? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10

To what degree do your problems affect your ability to perform at school, at home, and in your relationships with others? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10

When did these problems begin, and what was happening in your life at that time?

_____

_____

_____

_____

Current Habits

Please describe your current habits in each of the following areas:

Nicotine use:_____
THC use: _____
Other drug use: _____
Alcohol use: _____
Caffeine intake: _____
Exercise: _____
Eating: _____
Sleeping: _____
Fun and relaxation: _____

Client Interest in Counseling Services

Please describe what brings you (or your child/teen) to counseling:

_____

_____

_____

_____

_____

What are your goals for counseling? What would you like to achieve by attending counseling?

_____

_____

_____

How motivated do you feel to work on your goals? Do you have concerns about counseling or working on these issues?

_____

_____

_____

_____

_____

What are your positive qualities and skills? What do you like about yourself? What qualities have helped you to succeed at overcoming difficulties in the past?

_____

_____

_____

Form completed by: _____ Date: _____

Signature: _____