Counseling
by Penny Haight, M.Ed., LPC-S

Minor Intake Form

Child's Name_____**DOB**_____

Current Concerns:

What concern brings you or your child in?

When did this concern begin? (Please attempt to use dates.)

Has your family/child been in therapy before or received any prior professional assistance for your mental well-being? If so, please give dates:

What do you hope to accomplish in counseling for your child?

Please rate how much support you and your family have overall:

A Lot Some Limited Very Little None

Are there any cultural, religious, spiritual, or ethnic factors for your family that you would like me to be aware of? If yes, please describe:

What does your child enjoy doing in his or her free time, either on his/her own or with others?

What would you say are your child's strengths?

School Issues

Are you concerned about behavior at school? If so, explain.

Are you concerned about your child's academic progress at school?

Does your child enjoy school?

Physical Health

What activities does your child engage in to stay physically healthy? (i.e., exercise, sleep, diet, meditation, etc.):

Do you have any current concerns about your child's physical health? Please specify:

Does your child you have a physical/medical health provider? If yes, what is his or her name?

Please list medicines your child is currently taking, or has taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Medication: _____ Dosage:_____ Prescribed By:_____

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Physical Symptoms

Check any of the following symptoms that apply to your child:

Headaches ___

Stomach issues ___

Skin problems ___

Dizziness ___

Tics ___

Dry mouth ___

Palpitations ___

Fatigue ___

Burning /itchy skin ___

Muscle spasms ___

Twitches ___

Chest pains ___

Tension ___

Back pain ___

Rapid heart beat ___

Sexual disturbances ___

Tremors ___

Unable to relax ___

Fainting spells ___

Blackouts ___

Bowel disturbances ___

Use Laxatives ___

Excessive sweating ___

Tingling ___

Watery eyes ___

Visual disturbances ___

Numbness __

Flushes __

Hearing problems __

Don't like being touched __

Poor appetite __

Binge/Purge __

Constipation __

Allergies __

Nausea __

Substance Use

Please share information about the substances that you know/believe your child has used within the past year. Include street drugs, misuse of prescription medication, and use of medication not prescribed.

Substance- How much and how often? When last used? Age started using

Please share information about substance use by other people living in the child's home.

Mental Health History

Has anyone in the immediate family ever been hospitalized for psychiatric reasons? If yes, please provide dates:

Has anyone in the immediate family attempted suicide? If yes, when was the most recent attempt?

Does your child do things that other people might think are impulsive, risky, or dangerous? If yes, please describe:

Does your child have a history of abuse of any kind (sexual, physical, or verbal)?

Many people have the following experiences. Please circle any of these that you believe your child experiences more than other children:

Difficulty focusing or prioritizing

Irritable

Overactive/restless

Nightmares

Do or say things without thinking about the consequences

Can't stop thinking about a past experience

Hot temper

Anxious

Bad memory

Preoccupied with body weight or shape

Feel that people are conspiring against him/her

Do things that are harmful to self or others

Hear or see things that other people don't hear or see

Chronic relationship problems

Feel hopeless

Difficulty telling the truth

Thinking about suicide

Getting into physical fights

Weight loss/gain

Stressful home conditions

Intense highs and lows with his/her mood

Experiences that he or she does not understand

Can't slow down thinking

Homicidal thoughts

Panicky

Overly dependent on others

Extreme fear of a specific object, activity, or situation

Lack of motivation

Going out of my way to avoid things that he or she fears

Working too hard

Worry about what others might think of him/her

Crying/tearful

Feel driven to do things over and over ¨

Eating problems (i.e., not eating, binging, etc.)

Frequent, unwanted thoughts or images

Drinking or using drugs

If there is any other information you'd like to share with me on this form that was not covered in the questions above, please take the space below to do so.