wild hope COUNSELING
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Child/Adolescent Intake Form

This is a confidential record of minor's personal history. Please read consent form before completing this form. Information contained in it will not be released to anyone unless authorized by you or required by the law as explained in our consent form. You may opt to omit certain information. Your therapist may choose to discuss this information with you during session.

Date_____ Referred By_____

Client: Name_____ Male ❑ Female ❑

Address_____ City_____ Zip Code_____

Home Phone(_____)_____ Cell Phone(____)_____Minor's Cell Phone(_____)_____

May we call you at home? Y ❑ N ❑ At Work? Y ❑ N ❑ Student's grade level: _____

Person to notify in case of emergency_____Phone Number_____

Minor's Age_____ Birthdate_____/_____/_____

Ethnicity: Caucasian ❑ African American ❑ Hispanic ❑ Asian ❑ Other ❑ _____

NOTE: It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.
Would minor like spirituality/religious issues to be a part of your therapy? Y ❑ N ❑ Don't Know ❑

Minor: In your own words, please state the nature of the main problem:

Parent: In your own words, please state the nature of the main problem:

How would you rate how serious this problem feels to you? (Circle one) 1 2 3 4 5

Mildly Upsetting Extremely Serious

What would you like to accomplish through counseling?

CURRENT FAMILY SITUATION

Parents: Father: Age_____ Occupation_____

Mother: Age_____ Occupation_____

Marital Status of Parents ❑ Single ❑ Married ❑ Divorce ❑ Separated ❑ Living Together ❑ Other

Custody Arrangement (please be specific)_____

- Step-father: Age_____ Step-mother: Age_____

If divorced, please specify minor's age at divorce and circumstances surrounding divorce: _____

_____

Briefly describe minor's relationship with father_____

With minor's mother_____

Siblings: Brothers' first names and ages_____

Sisters' first names and ages_____

History: Please describe any family history of emotional or psychological problems:_____

_____

Describe any history of alcohol or drug use in the family:_____

_____

Is there any history of domestic violence, child abuse or sexual abuse in the family? *(Please note: Therapist may be required to report incidents to appropriate authorities)* _____

MINOR'S DEVELOPMENTAL HISTORY (If yes, please describe)

Pregnancy Planned ❑ Yes ❑ No Parents' Attitudes Toward Having Children _____

Complications with Pregnancy ❑ Yes ❑ No _____

Premature Birth ❑ Yes ❑ No _____

Age When: Crawled _____ Walked _____ Spoke First Word _____ Spoke First Sentence _____

Developmental Delays ❑ Yes ❑ No _____

MINOR'S EDUCATIONAL HISTORY (If yes, please describe)

School _____ Grade _____

Type of Class ❑ Regular ❑ RSP ❑ SDC ❑ Gifted _____

School Problems ❑ None _____

Skipped a grade ❑ Yes ❑ No _____

Held back a grade ❑ Yes ❑ No _____

MINOR'S CURRENT FUNCTIONING (If Yes, please describe)

Behavioral/School Problems ❑ Yes ❑ No _____

Problems with Parents ❑ Yes ❑ No _____

Problems with Siblings ❑ Yes ❑ No _____

Problems with Peer Relationships ❑ Yes ❑ No _____

Substance Abuse ❑ Yes ❑ No _____

Sexually Active ❑ Yes ❑ No _____

Any Cultural Issues? ❑ Yes ❑ No_____

MINOR'S MEDICAL CONDITIONS

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Back Pain	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑

OTHER CONCERNS

Smoking ❑ ❑ ❑ ❑

- Packs per week_____

Alcohol Intake ❑ ❑ ❑ ❑

- Frequency (per week):_____
- How Much? _____
- What do you drink? _____

Marijuana ❑ ❑ ❑ ❑

- Amount per week:_____

Drugs (not medications) ❑ ❑ ❑ ❑

- What? _____
- Frequency:_____

MINOR'S MEDICATION HISTORY

Please check all that apply to you:

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Other (please specify)	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments:

Has minor experienced significant weight gain or loss in last 12 months? Y ❑ N ❑

Does minor exercise regularly? Y ❑ N ❑ How?_____

Does minor sleep well? Y ❑ N ❑ Amount (hours)_____ Easy to get to sleep? Y ❑ N ❑

What recreation does minor enjoy?_____

Physician_____ City_____ Date of last physical_____

The hardest time in minor's development was: Preschool ❑ Grade School ❑ Jr. High ❑ High School

Please describe:

MINOR'S TREATMENT/THERAPY HISTORY

Has minor ever had any previous counseling or psychotherapy? Y ❑ N ❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Any previous diagnoses? Y ❑ N ❑ If YES, describe: _____

Has minor ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Has minor ever been hospitalized for psychiatric reasons? Y ❑ N ❑

- If YES, when? _____ Length of hospital stay _____

ADDITIONAL INFORMATION

What are minor's strengths/talents? _____

_____

_____

_____

_____

Additional comments: _____

_____

_____

_____

_____

Following information for parent primarily responsible for payment:

Name _____

Occupation _____ Employer _____

Employer's Address _____ Phone _____

Annual Household Income _____ Do you own or rent? _____

How do you intend to pay for treatment? _____