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MINOR INTAKE FORM

Minor Name:			
Minor Age:	**Minor DOB:**		
Primary Address of Minor:			
Minor Telephone number if Applicable:	**Home:**	**Cell:**	
Can I leave a message at the above number?	**YES/NO**	**YES/NO**	

Please include Parent/ Guardian information:

Name:			
Age:	**DOB:**		
Address:			
Telephone numbers:	**Home:**	**Work:**	**Cell:**
Can I leave a message at the above number?	**YES/NO**	**YES/NO**	**YES/NO**
Preferred way to be contacted (circle one):	**Home**	**Work**	**Cell**
May I contact you by E-mail? YES/NO		**Email:**	

Emergency Contact

Name:	**Relationship:**
Phone Number:	**Address:**

Children: (List all children, including biological, adopted, foster, and step children of Parent/Guardian)

Name	Age	Relationship	City, State	Lives at home?
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO
				YES/NO

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Has minor ever been abused in any way? YES/NO	**If yes please circle type:** Physical Emotional Sexual Neglect Other **Please explain:**

Does minor have a primary care physician? YES/NO	**Physicians name:**
Is minor under the care of a psychiatrist? YES/NO	**Psychiatrists name:**

Is minor under the care of a specialist? YES/NO
If yes, please describe:

Please list any chronic illness, disabilities, or medical conditions that minor has been diagnosed with:

Illness/Disability	Dates

List all medications minor is currently taking:

Medication	**Dosage**	**Treating**
Is minor taking the medications according to doctor's recommendation? YES/NO If No, briefly explain:		

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Does minor have history of self-mutilating/ cutting behavior? YES/NO
If yes, describe briefly and indicate dates:
Has minor ever mentioned thoughts of suicide? Or have a history of suicide attempt? YES/NO
If yes, describe briefly and indicate dates:

Therapy Experiences and Expectations:

Is minor currently seeing another therapist? YES/NO			
If yes, please indicate the therapist's name:			
Has minor ever been in therapy in the past? YES/NO			
If yes, please fill out the following on your previous counseling experience(s):			
Therapist	**Location**	**Dates**	**Reason for therapy**

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Briefly describe reason(s) for seeking therapy at this time:

What goals do you wish to accomplish during the therapy process?

Is there anything else you would think would be important for me to know about you and your family?