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Minor Intake Form

Personal Information:

Name: ____Gender: __________Date:__________________________

Age:____________ Ethnicity: _______________________ Date of Birth: _________________________________

Parent #1	Parent #2
Name:	Name:
Phone Number:	Phone Number:
Employer:	Employer:

Parents divorced? Y/N

If yes, what is the custody arrangement?____

____

Contact Information:

Patient Home Address:_______________________________________City:_______________________________

State: _________ Zip:____________ Email(Parent): ____

May I mail you at this address: ________Yes ________No; May I email you? _____Yes _____No

Home Phone Number:_____________________________ Cell Phone Number_____________________________

Okay to call house? Y/N; leave message? Y/N

Okay to call cell? Y/N; leave message? Y/N

Emergency Contact ____________________________________ Phone: __________________________________

Emergency Contact's Relationship to Minor: ________________________________

Medical Doctor(s) (name/phone):____

Reason for Seeking Therapy (be as specific as you can: when did it start, how does it affect child...):

____

____

____

____

____

____

____

9404 Genesee Ave, Suite 245
La Jolla, CA 92037
P: 858.633.6463
F: 858.246.6266

Has your child been in therapy before? If so, when and why? Whom did they see?

____

____

____

What are his/her main worries and fears?

____

____

What do you identify as you're his/her strengths?

____

____

What do you identify as his/her weaknesses?

____

____

Please check if there has been any recent changes in the following:

- — Sleep patterns
- — Physical activity level
- — Eating patterns
- — General disposition
- — Behavior
- — Weight
- — Focus
- — Energy level
- — Nervousness/Tension
- — Other (specify)_________________

Describe changes in areas in which are checked above:

____

What would do you see the focus of your child's therapy to be?

____

____

____

Assuming that your child achieved their goals for coming to therapy, what would some of their gains look like?

____

____

____

Family Information:

Parent/Step Parent: (name/age, occupation, personality, brief statement about relationship with the child):

Father: ____

____

Mother: ____

____

Step Parents: ____

____

If Parents are divorced, what was your child's age at the time:____

Describe how it has affected him/her____

____

Siblings: (name/age, and brief statement about the relationship):

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Who lives with the child? List everyone in the household, relationship, and ages:___________________________

____

____

____

____

What would you list as family values?____

____

How much time do you spend together as a family per week?_______________________________________

What is your view on technology use within the family? (i.e. TV, Computer, Phone, Ipod, Ipad etc.)__________

____

School:

School Name:____

Teachers Name:____ What grade level is the child in?_____________

How are his/her grades? Poor/Fair/Average/Good/Very Good

Does your child have a documented learning disability or other condition? Y/N ___________________________

____

How would you describe his/her functioning in school? (Gets along with teachers/students, is shy, outgoing, attendance, etc.)____

____

____

Has the child been expelled or suspended? Y/N

Does he/she cut classes? Y/N

Is he/she in remedial classes? Y/N

Is he/she gifted or talented? Y/N

How does the school/teacher view the child? (e.g. hyperactive, timid, achiever, procrastinator etc. ___________
____

May I contact the teacher or school psychologist to discuss the child? Y/N

If so, please provide phone number:____

Development:

Was the pregnancy planned? Y/N Is the child adopted? Y/N

Were there any prenatal complications? Y/N Explain:_______________________________________
____

Were there any birth complications? Y/N Explain:____
____

Did the child meet developmental milestones? Y/N Explain:__________________________________
____
____

Any history of significant trauma? Y/N Explain:____
____

Physical Abuse? Y/N Sexual Abuse? Y/N Domestic violence between parents? Y/N

If yes, please explain:____
____

Family Medical and Psychiatric History:

Describe any physical or mental illnesses that run in the family including depression and/or suicide:
____
____

Describe any abuse of substances that run in the family:
____
____

Describe any history of violence or emotional/physical abuse:
____
____

Past/Present Psychotherapy: Please specify the month year(s) (beginning-end), estimated number of sessions, name and degree of therapist, initial reason for therapy, brief description of the relationship and how helpful it was, and how/why it ended):
____
____
____
____

Has your child ever experienced any of the following:

	Yes	No	When	Where	Reaction to experience
Therapy/Counseling	___	___	__________	____________	________________________
Suicidal Thoughts/Attempts	___	___	__________	____________	________________________
Drug/Alcohol Treatment	___	___	__________	____________	________________________
Hospitalizations	___	___	__________	____________	________________________

If your child has ever experienced suicidal thoughts/suicide attempt(s) or any other violent behavior, please describe (described: ages, reasons, circumstances, how etc.):

____

____

Please check behaviors and symptoms that occur to him/her more often than you would like them to take place:

— Aggression
— Anger
— Anxiety
— Avoiding people
— Avoiding school
— Bedwetting
— Boredom
— Cheating
— Chest pain
— Crying
— Cursing
— Cyber addiction
— Depression
— Dieting
— Distractibility
— Dizziness
— Drug use
— Eating disorder
— Elevated mood
— Fatigue
— Focus problems
— Hallucinations
— Heart palpitations
— Homework difficulties
— Hopelessness
— Impulsivity
— Irritability
— Judgment errors
— Loneliness
— Low self-esteem
— Lying
— Memory impairment
— Mood shifts
— Nightmares
— Panic attacks
— Phobias/fears
— Sexual behavior
— Sick often
— Sleeping problems
— Speech problems
— Stealing
— Suicidal thoughts
— Social Media Issues
— Throwing things
— Trembling
— Tummy ache
— Texting
— Withdrawing
— Worrying
— Yelling
— Other

Briefly discuss how the above symptoms impair his/her ability to function effectively:______________________

____

____

____

Medical/Physical Information:

Past/Present Medical Care (major medical problems, surgeries, accidents, falls, illness-please include dates):

____

____

____

List any current health concerns:____

List any recent health or physical changes:____

Is your child taking any medication(s) at this time? Y/N__________________________________

Prescription Drugs:

Type	Amount	Frequency	Date Last Used

Has or does he/she use(ed) any of the following?

Coffee/Caffeinated Beverage/ Energy Drinks Y/N How much/How Often______________________

Cigarettes Y/N How Much/How Often?______________________

Alcohol Y/N How Much/How Often?______________________

Marijuana Y/N How Much/How Often?______________________

Other Drugs Y/N How Much/How Often?______________________

Does someone in your family present/past have/had a problem with drugs or alcohol? ___Yes ___No

If yes, describe:____

Please check any medical/physical health issues that apply to your child/adolescent:

— Abdominal pain
— Abortion
— Allergies
— Anemia
— Appendicitis
— Arthritis
— Asthma
— Bronchitis
— Bedwetting
— Cancer
— Chest pain
— Cold/cough's
— Constipation
— Chickenpox
— Dental problems
— Diabetes
— Diarrhea
— Dizziness
— Drug abuse
— Epilepsy
— Ear infections
— Eating problems
— Fainting
— Fatigue
— Frequent urination
— Headaches
— Hearing problems
— Hepatitis
— Measles
— Mononucleosis
— Mumps
— Menstrual pain
— Neurological disorders
— Nausea
— Nosebleeds
— Sleeping disorders
— Sore throat
— Scarlet fever
— Sinusitis
— Stroke
— Tonsillitis
— Tuberculosis
— Toothache
— Thyroid problems
— Vision problems
— Vomiting
— Whooping cough
— Other

Nutrition:

Meal	How Often	Typical Foods Eaten	Typical Amount Eaten
Breakfast	___/week	____________________	__low __med __high __none
Lunch	___/week	____________________	__low __med __high __none
Dinner	___/week	____________________	__low __med __high __none
Snacks	___/week	____________________	__low __med __high __none

Comments:____

____

Does your child engage in eating disordered behavior? ___Yes ___No

If yes, describe: ___Restricting ___Binging ___Purging ___Extreme Diets ___Other:_________________

How does he/she feel about their body?____

How much physical activity does he/she engage in daily?____

Social Relationships:

Check how he/she generally gets along with other people: (check all that apply)

__Affectionate __Aggressive __Avoidant __Fight/Argue Often

__Friendly __Follower __Leader __Outgoing

__Shy/Withdrawn __Submissive __Other (specify)_________________

Any concerns about social relationships? (Specify)

____

____

Does your child get teased? Y/N ____

Does your child tease others? Y/N ____

Does your child/adolescent have a cell phone? Y/N

If yes, how much time do they spend on it each day?_____________

Are they on Social Media? Y/N Please describe:____

Do you monitor their use of social media? Y/N

Culture/Ethnic:

To which cultural or ethnic group, if any, does he/she identify?______________________________________

Are they experiencing any problems due to cultural or ethnic issues? ___Yes ___No

If yes, describe:

____

Other Cultural/Ethnic

Information:____

Religious/Spiritual:

How important to him/her are spiritual matters? ___Not ___Little ___Moderate ___Much

Are you or your family affiliated with a spiritual or religious group? ___Yes ___No

If yes, describe:____

Is he/she being raised within a spiritual or religious group? ___Yes ___No

If yes, describe:____

Would your child prefer spiritual/religious beliefs to be incorporated into the therapy? ___Yes ___No

If yes, describe:____

Leisure/Recreational:

Describe his/her special areas of interest or hobbies (e.g. art, books, crafts, sports, clubs, music, outdoor activities, church activities etc.)

Activity	How often now?	How often in the past?

Friendships, Community, and Spirituality (describe quality, frequency, activities, etc.):

____

____

____

What gives your child the most joy or pleasure in life?

____

____

Referral Source:

How were you referred to me?

____

If it was on the internet, what search engine and phrases did you use?

____

Have you visited my website? _______ Yes _______ No If so, was it helpful? _______ Yes _______ No

How so? ____

Financially Responsible Person's Information:

Name ______________________________ Relationship to Client ______________________________

Phone (if different from above) ____

Address (if different from above) ____