



Child/Adolescent Intake

Child Name: _____ DOB: _____

Address: _____ City _____ Zip _____

Sex Male Female Age: _____

School attending _____ Grade (current or entering) _____

Is patient adopted? Yes No If yes, at what age? _____

Race/Ethnicity

Caucasian Native American Multiracial _____
 African American Asia Latin or Spanish Other _____

Biological Parents (or Guardian information):

Are Biological parents divorced or separated? Yes No If yes, for how long _____

*If yes, do parents share custody? Yes No ** Court documentation must be provided*

Parent: _____ Relationship _____

Phone: _____ okay to leave msg? Yes No

Occupation: _____

Email: _____ okay to use email? Yes No

Co-Parent: _____ Relationship _____

Phone: _____ okay to leave msg? Yes No

Occupation: _____

Email: _____ okay to use email? Yes No

Siblings (include biological, adopted, foster, step, etc.)

<u>Name</u>	<u>Sex</u>	<u>Age</u>	<u>Type (bio,step,etc.)</u>	<u>Custody?</u>
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Anyone else living in your household other than parents or siblings? Yes No

***If yes, please give name(s) and relationship:

Person to contact in case of emergency

Phone Number



COUNSELING HISTORY OF CHILD/ADOLESCENT

Prior counseling experience:

From: _____ To: _____ With Whom? _____

How were you referred to me? _____

Is there any history of mental health issues in family? (if yes, please describe) _____

Basic Health Good Fair Poor Date of last exam? _____

Physician's Name: _____ Phone: _____

Is child/adolescent taking any prescription medication at this time? Yes No

If yes, what? _____

Is child/adolescent taking any over the counter medication at this time? Yes No

If yes, what? _____

Current reason for seeking counseling

Are there any physical, emotional, or mental issues now or in the past that I need to be aware of? Yes / No

If yes, what? _____

Has child/adolescent ever been hospitalized? Yes / No

If yes, for what and when _____

Briefly describe the problem for which you wish your child/adolescent to have counseling:

The thing that concerns me most right now is: _____

Counseling would be successful if: _____

I understand that suicidal threats, homicidal threats or child abuse will be reported.

I understand that the parent must facilitate the ability for child/adolescent to trust the therapist and will respect confidentiality when appropriate.

Parent (s) Signature : _____

Print names : _____

Adolescent Signature: _____



Initial Service Plan

Please check any of the reasons listed below which resulted in your coming in today:

- | | |
|---|---|
| <input type="checkbox"/> Depression or Anxiety | <input type="checkbox"/> Difficulty with loss or death |
| <input type="checkbox"/> Alcohol or other drug abuse | <input type="checkbox"/> School adjustment problems |
| <input type="checkbox"/> Communication Difficulties | <input type="checkbox"/> School learning difficulties |
| <input type="checkbox"/> Harm to self or others | <input type="checkbox"/> Low Self Esteem/social withdraw/motivation |
| <input type="checkbox"/> Abuse (physical/verbal/sexual) | <input type="checkbox"/> General Defiance |
| <input type="checkbox"/> Sexual Orientation Questions | <input type="checkbox"/> Staying Focused/Task Completion |
| <input type="checkbox"/> Child Adjustment/Parent Conflict | <input type="checkbox"/> Eating Disorder/Obesity |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Individual Counseling |
| <input type="checkbox"/> Adoption | <input type="checkbox"/> Family Counseling |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

What event happened which made you think "I am (we are) calling a therapist?" _____

Modality – who would you like to see participate in counseling?:

What behaviors would you like to change? _____

Patient's strengths and interests: _____

Specific Goals identified (can be completed with therapist)	Plan Review Date: 6 months from intake
_____	_____
_____	_____
_____	_____

Patient Signature _____ Date _____

Parent Signature _____ Date _____

Signature _____ Date _____
Lauren Melendez, M.S., LAMFT

Supervisor Signature _____ Date _____
Dr. Nancy Frigaard, D.Min., LMFT 15231