Intake for Child/Adolescents
Parental Consent for Treatment of a Minor

Child's Name: _____Date: _____

Child's Age: _____ Date of Birth: _____ Gender: ☐ Male ☐Female

Full Address: _____

_____

Phone Numbers: Home: _____ Cell: _____

Would you like a text reminder? Yes ☐ No ☐

E-mail: _____

Emergency Contact: Name: _____

Phone Number: _____

Relationship to Client: _____

Parents/Step-Parents:

	Name
Mother	
Father	
Step-Parent 1	
Step-Parent 2	

Marital status of parents: Married ☐ Separated ☐ Divorced ☐ Other ☐

With whom does the child live?

_____

Custody: ☐ Lives in one home with both legal parents ☐ Mother has physical custody
☐ Father has physical custody ☐ Physical custody is shared

Office Use Only:	If divorced, divorce decree on file? ☐ Yes	☐ No

List all people living in the household:

Name	Age	Relationship to Child

List all siblings living outside the home:

Name	Age

Are you presently involved in any legal situation? Yes _____ No _____

If yes, please briefly describe:

_____

INSURANCE

Insurance Company

_____

Please specify if you have BCBS from another state

_____

Insurance Phone _____

I.D. Number _____ Group Number _____

Client's relationship to Insured (circle one): Self Spouse Child Other

Insured Name (Last, First MI) _____

Insured's Street Address _____

Insured's City _____ Insured's State _____

Insured's Zip Code _____ Insured's Phone Number _____

Insured's Date of Birth (e.g. 3/4/1956) _____

Insured's Employer: _____

PRESENTING PROBLEM

Briefly describe your child's current difficulties:

_____

_____

How long has this problem been of concern to you? _____

SOCIAL AND BEHAVIOR CHECKLIST

Place a check next to any behavior or problem that your child currently exhibits.

☐ Speech Difficulty	☐ Aggressive	☐ Sexual Behavior Not Appropriate for His/Her Age
☐ Hearing Difficulty	☐ Shy or Timid	☐ Intense Reaction to Critism
☐ Language Difficulty	☐ Self-harming Behaviors (Cutting)	☐ Does Not Show Affection
☐ Vision Difficulty	☐ Impulsive (Acts rashly, without thinking)	☐ Eats Poorly
☐ Coordination Difficulty	☐ More Interest in Object than in People	☐ Stubborn
☐ Prefers to be Alone	☐ Sudden or Extreme Mood Changes	☐ Much Too Active
☐ Does not get along with others	☐ Frequent Nightmares	☐ Resists Being Comforted When Hurt
☐ Special Fears, Habits, Mannerisms	☐ Blank Staring Spells	☐ Gives Up Easily
☐ Lacks Guilt or Empathy	☐ Slow to Learn from Mistakes	☐ Show Intense and Inappropriate Anger

Engages in behavior that could be dangerous to self or others? ☐ Yes ☐ No

If yes, describe _____

Has trouble sleeping? ☐ Yes ☐ No

If yes, describe _____

EDUCATIONAL HISTORY

School: _____Grade: _____

Place a check next to any educational problem that your child currently exhibits:

☐ Reading Difficulty	☐ Spelling Difficulty	☐ Difficulty with Other Subjects
☐ Math Difficulty	☐ Writing Difficulty	☐ Does not like School

Is your child in a special education class? ☐ Yes ☐ No

If yes, what type of class? _____

Has your child been held back in a grade? ☐ Yes ☐ No

If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been suspended or expelled? ☐Yes ☐No

If yes, please describe: _____

CURRENT HEALTH INFORMATION

Describe child's health generally: ☐Good ☐Fair ☐ Poor

List any health problems the child has had: _____

Is your child on medication at this time? ☐ Yes ☐No If yes, please fill out the following:

Medication	Dosage and How often taken	Doctor Prescribing	Prescribed for…

PREVIOUS COUNSELING/PSYCHOTHERAPY

Has your child ever been to counseling or seen a psychiatrist? ☐Yes ☐No

If yes, please fill out the following:

Age	Duration	Counselor or Doctor's Name	Issue(s) and Diagnosis

Has your child ever participated in/attended?

☐ Inpatient ☐ Day Treatment ☐Substance Abuse Program
☐ Psychological Testing ☐ Partial Hospitalization ☐ Intensive Outpatient Program

Explain any of the above: _____

Has the child ever:

Made a Suicide Attempt? ☐Yes ☐ No
If yes, please describe (when, where, means, intervention) _____
_____

Expressed Homicidal Thoughts? Yes No
If yes, please describe (when, where, means, intervention) _____
_____

SOCIAL MEDIA

Does your child participate in Social Media? Yes_____ No_____

If yes, what platforms (ex. Twitter, Facebook, SnapChat, Instagram) do they use?
_____

Do you have access to social media accounts? Yes_____ No_____

If yes, please explain:_____

Does child have limits on their social media usage? Yes_____ No_____

If yes, what type of limits are in place for social media? _____

I certify that the above information is true to the best of my knowledge. I authorize Bonnie Givens, Licensed Professional Counselor, to evaluate and treat the minor listed below:

_____ _____
Parent/Guardian Signature **Date**

_____
Client's name (printed)