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Counseling Services
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Parent/Child Confidential Client Intake Form

Welcome! Please fill out the following as completely and legibly as possible. If you have concerns about the relevance of any information and wish to leave it out, please feel free to do so.

Parent's name(s):

Address:

City:

State: Zip/Postal Code:

Phone number(s): Ok to leave a message? □ Yes □ No

Is it ok to text? _____Yes _____No

Email Address:

Age:

Cultural Background/Ethnicity:

Religious/Spiritual Orientation:

Current employment:

Person to alert in the event of medical emergency:

Relationship to you: Phone:

Relationship status (circle one): Single Married Partnered Separated Divorced Widowed

Who currently lives in your household (gender, age, relationship)?

Do you have pets? Describe:

Please provide any significant information about family history and family psychiatric/mental illness history:

In your own words, what is the nature of the concern that you would like to see addressed in therapy?

How long has problem persisted?

Please provide the following information about your child:

Child's Full Name:_____

Nickname:_____

Birth Date: _____ School/Grade:_____

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like? What are his/her strengths?

What motivates your child or is special about your child that you have not mentioned yet?

Challenges:
What is difficult for your child right now? Does he/she have any behavioral, academic, emotional or social challenges that need to be addressed?

Treatment Goals:
What is your top priority for your child's treatment goals?

Medical History:

What is the name of your child's medical doctor?_____

Address: _____ Phone:_____

Date of your child's last medical examination:_____

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe:

Has your child experienced any of the following medical problems?

A serious accident____Hospitalization____Surgery____Asthma____A head injury____High fever____ Convulsions/seizures____Eye/ear problems____ Meningitis____Hearing problems____Allergies____Loss of consciousness____Other_____

Please list any current medical problems or physical issues:

Please list any medications your child takes on a regular basis:

Please list any issues that your child may be experiencing socially, emotionally or academically:

Has your child ever:

Had previous psychological care or counseling? □ Yes □ No
If yes, please describe_____

Had chronic medical issues? □ Yes □ No
If yes, please describe_____

Had suicidal thoughts, attempted suicide? □ Yes □ No
If yes, please describe_____

Experienced difficulties with substance use/abuse? □ Yes □ No
If yes, please describe_____

Been a victim of physical, sexual, and/or psychological abuse? □ Yes □ No
If yes, please describe_____

Had legal trouble? □ Yes □ No
If yes, please describe_____

Had an eating disorder? □ Yes □ No
If yes, please describe_____

Made statements of wanting to hurt him/herself or seriously hurt someone else? □ Yes □ No
If yes, please describe_____

Finally, what are some of the things that are currently stressful to your child and his/her family?

Therapy can be a powerful force for change. In order for it to be most effective it helps to have a clear and specific goal. You may find it difficult to express your hopes for therapy in the form of a goal; that's ok! This information will be a starting point for us to discuss during the initial sessions. Feel free to list more than one goal if you wish.Thank you for taking the time to complete this form. When we meet, please feel free to ask me any questions about this form, or to tell me anything else that you would like me to know.

Prior to your first appointment, please also take some time to review the attached professional disclosure statement. We will discuss this document again during our first meeting.

My signature below indicates I have received a Professional Disclosure Statement (PDS) from Andie DeSha, understand the information provided in the PDS, and consent to counseling treatment for my child.
_____

Client Signature_____ Date_____

Counselor Signature_____ Date_____

I affirm that I am the legal guardian of _____.

With an understanding of the above requirements, I do grant permission for my minor to participate in counseling.

Parent/Guardian's Signature: _____
Date: _____

I acknowledge that I have received a copy of this consent form _____ (Initial)

Therapist Signature: _____
Date:_____