The Center for Counseling & Training

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Youth Counseling Intake Form

**This form is information regarding the minor client (not the parent/guardian)*

Date: _____ D.O.B. _____

Full Name: _____ SS#_____ Gender: M☐ F☐

Others Living in the Home:

Name: _____ D.O.B. _____ School/Employer: _____

Name: _____ D.O.B. _____ School/Employer: _____

Name: _____ D.O.B. _____ School/Employer: _____

Name: _____ D.O.B. _____ School/Employer: _____

Physical and Mental Health History: (Please be accurate, records may need to be disclosed at some point)

General Health: EXCELLENT☐ GOOD☐ FAIR☐ POOR☐ DON'T KNOW☐ Comments: _____

Primary Care Physician: _____Date of Last Visit: _____

Address: _____ Phone Number: _____

Is this child currently under the care of a psychiatrist? Yes☐ No☐ If yes, name of provider:_____

Is this child currently taking medication? YES☐ NO☐ List of medication(s): _____

Allergies: _____ Adverse Reaction to Medications: _____

Ever hospitalized for physical illness? YES☐ NO☐ Describe: _____

Ever hospitalized for mental illness? YES☐ NO☐ Describe: _____

History of mental illness in family: YES☐ NO☐ Describe: _____

Recent surgery/illness? YES☐ NO☐ Describe: _____

Chronic/recurrent illness? YES☐ NO☐ Describe: _____

Physical and Mental Health History (cont'd):

Does this child smoke? YES☐ NO☐ If yes, how much: _____

Has this child ever used illegal drugs? YES☐ NO☐ If yes, describe._____

Has this child ever drank alcohol? YES☐ NO☐ If yes, describe_____

Has this child ever witnessed domestic violence or other types of violence? YES☐ NO☐ Describe: _____

Has this child ever attempted, or threatened to harm him/herself? YES ☐ NO ☐ Describe: _____

Has this child ever attempted, or threatened to harm anyone else? YES ☐ NO ☐ Describe: _____

Has this child previously attended counseling/therapy? YES ☐ NO ☐

If YES:
Name of Agency: _____ Counselor: _____ Dates seen: _____

Mother's Health during Pregnancy: Good ☐ Fair ☐ Poor ☐ Describe: _____

During the pregnancy; did the mother:
Take any medications: YES ☐ NO ☐ Please list: _____
Drink alcohol? YES ☐ NO ☐ If yes, how much: _____
Smoke cigarettes? YES ☐ NO ☐ If yes, how much: _____
Recreational drugs? YES ☐ NO ☐ If yes, what/how much: _____

Education:
Is this child currently in school? YES ☐ NO ☐ Grade: _____ Name of School: _____

Does he/she like school? YES ☐ NO ☐ Explain: _____

Favorite Classes: _____ Hardest Classes: _____

Does child get in trouble at school? ☐ YES ☐ NO If yes, explain/addt'l info___: _____

Does child avoid going to school? YES ☐ NO ☐ If yes, how often? _____

How often is the child absent from school? _____ If often, why? _____

How are the child's grades? _____ Comment: _____

Retained a grade? YES ☐ NO ☐ Which? _____ Skipped a grade? YES ☐ NO ☐ Which? _____

Have an IEP or 504 Plan? ☐ YES ☐ NO Comment: _____

Has child changed schools for reasons other than normal academic progression? YES ☐ NO ☐ If yes, when/why? _____

_____

If not in school, please describe your situation: _____

Stressors Affecting your Child: (Check all that apply)

___ Home
___ Peer
___ School
___ Grades
___ Family
___ Siblings/Step
___ Step Parent
___ Losses
___ Parent Conflict
Other: _____

Social History : (Check all that apply)

___ Reading problems
___ Writing problems
___ Math Problems
___ Other learning problems
___ Spelling problems
___ Distractibility

___ Not paying attention
___ Not completing work
___ Loss of contact with reality
___ Apparent intoxication
___ Toileting problems
___ Lack of motivation
___ Threatening other children/bullying
___ Sex play with other children
___ Anger outbursts
___ Difficulty with transitions
___ Sleep problems

___ Disturbing other children
___ Defiance toward authority
___ Excessive fantasizing
___ Repeated violations of school rules
___ Difficulty following instructions
___ Overreaction to discipline
___ Bullied by others
___ Easily frustrated
___ Prefers to be alone
___ Nervous habits

___ Difficulty expressing self
___ Excessive talking
___ Repetitive behaviors
___ Excessive anxiety
___ Daydreaming
___ Excessive activity level
___ Seems unhappy most times
___ Difficulty with friendships
___ Excessive fears or worries
___ Anxiety attacks

What does your child and family do for fun? (Check all that apply)
___ Games ___ Sports ___ Outings ___ School Functions ___ Movies ___ Other:_____

What are your child's assets? (Check all that apply)
___ Academics
___ Music
___ Art
___ Sports
___ Helpful
___ Good Natured
___ Plays well with others
___ Cooperative
___ Other: _____

Misc. Information:

Religious Preference (if any): _____
Activities/Clubs: _____

Present Situation:

Why did you decide to bring your child for counseling/therapy? _____

_____

What would you and/or your child like to get from counseling/therapy? _____

_____

_____

Are there any legal issues going on with your family? If yes, please describe: _____

_____

_____

Any additional information you would like to share? _____

_____

_____

_____ _____ _____
Signature of parent/guardian Relationship to child Date

The Center for Counseling & Training, LLC

For office use only:
Has parent/guardian provided a copy of current legal custody agreement ***at intake***, if applicable? Yes☐ No☐
Staff will place the copy in the client's hard copy file.