SERVINGLEADERS

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Individual Counseling Intake Form *(For a Minor)*

A. CLIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Gender: [ ] Male [ ] Female

B. PARENT/ GUARDIAN(S) INFORMATION (If client is under the age of 18)

Name(s): Relationship to Client: _____

Address: _____ City: _____ State: ____ Zip: _____

Preferred Phone: _____

Email: _____

Occupation(s): _____

Employer(s): _____

Current Church Affiliation: _____

Do you serve in a leadership role? (If so, what?) _____

If biological parents are not living together, what is the legal custody agreement?:

_____

Referred by: _____

C. EMERGENCY CONTACT

Name: _____ Relationship to Client: _____

Phone: _____ Email:_____

D. INTAKE INFORMATION

Has your child ever had counseling before? If yes, list name of counselor, reason for counseling, and dates seen:

1) _____

2) _____

3) _____

How would you describe their experience with/response to counseling in the past?

_____

_____

What has led you to seek counseling for them now?

_____

_____

_____

What areas of your child's life are being impacted by the difficulties affecting them?

[ ]Home [ ]Family [ ]School [ ]Friends/Community

Has your child ever or are they currently experiencing any of the following experiences or behaviors? (check all that apply)

❏ Alcohol abuse
❏ Drug use
❏ Impulsivity
❏ Concerns about finances
❏ Changes in sleeping habits

❏ Changes in appetite ❏ Feeling lonely
❏ Abuse (physical, verbal, emotional or sexual)
❏ Stress
❏ Feeling trapped in rooms/buildings/cars
❏ Hearing voices
❏ Overwhelming fear
❏ Panic attack(s)

❏ Chronic lying /stealing ❏ Increased anxiety/worry ❏ Unusual indecisiveness ❏ Inability to control thoughts ❏ Guilt
❏ Loss of concentration ❏ Feeling sexually attracted to members of your own gender ❏ Distrustful
❏ Hopelessness
❏ Hostile/angry/violent ❏

Feelings of being watched ❏ Loss of sexual desire ❏ Feeling distant from God ❏ Concerns about body image ❏ Frequent depressed mood ❏ Fatigue/low energy
❏ Hallucinations
❏ Obsessions/compulsions
❏ Apathy/Loss of interest

Has your child ever mentioned experiencing thoughts of suicide? [ ] yes [ ] no

Please describe what you hope for your child to accomplish/receive through this process:

_____

_____

_____

E. FAMILY INFORMATION

Parents' current marital status. If parent(s) are no longer living, please indicate their marital status before passing.

❏ Married
❏ Separated for ___ years
❏ Divorced for ___ years

No
❏ Mother remarried ____ times ❏ Father remarried ____ times ❏ Never married

Is your child your biological child? [ ] Yes [ ]

List all siblings, deceased or alive, with ages, starting with the oldest (include this child):

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Are there now or were there ever any circumstances that kept the child away from his/her parents/guardians for an extended period of time? (sickness, legal problems, etc.) : [ ]Y [ ]N
If yes, please explain:

_____

Please describe your child's family experience (from your perspective):

❏ Optimal/Secure ❏ Adequate/Supportive ❏ Distant/Disconnected

❏ Controlling/Rule-bound
❏ Chaotic/Overwhelming
❏ Abusive/Unsafe

Is there a history of mental illness in your family (anxiety, depression, suicide, bipolar, schizophrenia, etc.)?

❏ Yes
❏ No
❏ Not Sure

If yes, please indicate which family members experienced mental illness (and explain):

❏ Father
❏ Mother
❏ Sibling(s)
❏ Grandparent(s)

❏ Spouse
❏ Child/children
❏ Step-parent/sibling (live-in) ❏ Other

Is there a history of alcohol/drug abuse in your family?

❏ Yes
❏ No
❏ Not Sure

If yes, please indicate with which family members (and explain):

❏ Father
❏ Mother
❏ Sibling(s)
❏ Grandparent(s)

❏ Spouse
❏ Child/children
❏ Step-parent/sibling (live-in) ❏ Other

Is there anything else the counselor needs to know about your child's home or family situation?:

_____

_____

What support does your child have in their life (Family, Friends, School, Social/Community, Church)?

_____

_____

F. MEDICAL INFORMATION

Primary Care Physician: _____

Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Were there any complications surrounding your child's birth?: [ ]Y [ ]N

If yes, please explain: _____

_____

Has the child experienced any significant developmental delays? [ ]Y [ ]N

If yes, please list the area of concern and any treatment the child may have received:

_____

_____

_____

How would you describe your child's current physical health? [ ] Good [ ] Fair [ ]Poor

Please list any medications your child is currently taking (include dosage, amount and how long):

1) _____
2) _____
3) _____

Has your child had any serious conditions, illnesses, injuries and/or hospitalizations in the past?
(Please list with approximate dates.)

1) _____
2) _____
3) _____

G. SCHOOL INFORMATION

Name: _____

Grade/Degree: _____

Address: _____ City: _____ State: ____ Zip: _____

School Counselor: _____

Phone: _____

Can I contact if needed? [ ]Yes [ ]No

How is your child performing academically?: _____

Does your child engage with peers at school?: [ ]Y [ ]N

Does your child complete his/her assignments?: [ ]Y [ ]N

Does your child get along well with his/her teachers?: [ ]Y [ ]N

Is there anything else about your child's experience at school that you would like their counselor to know?

_____

_____

_____

_____

Is there anything else that you would like your child's counselor to know?

_____

_____

_____

_____