# POSITIVE FRAME OF MIND COUNSELING PLLC

# CHILD/TEEN INTAKE FORM

**Note: This information is confidential.**

Client Name: ____________________________________________________________ DOB: ______________

Parent/Guardian:____________________________________________________ Date:____________________

Reason for seeking counseling: ___________________________________________________________________

_____________________________________________________________________________________________

Is the client currently under a physician's care? Yes or No

Physician:_________________________________________________________

Names of Physicians/Specialists who are treating you:_________________________________________________

_____________________________________________________________________________________________

| Problems/Symptoms | Past | Present | Not Applicable | Explanation |
|---|---|---|---|---|
| Change of Appetite | | | | |
| Binging/purging food | | | | |
| Weight loss/gain | | | | |
| Insomnia/hypersomnia | | | | |
| Depression | | | | |
| Mood Swings | | | | |
| Anxiety | | | | |
| Abuse/Neglect | | | | |
| Anger Management | | | | |
| Hallucinations/Delusions | | | | |
| Low Self Worth | | | | |
| Poor concentration | | | | |
| School attendance problems | | | | |
| Aggression | | | | |
| Sexually Acting Out | | | | |
| Hyperactivity | | | | |
| Nightmares/night terrors | | | | |
| Poor relations with peers | | | | |

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## Education

What school are you enrolled in? ____________________________________________

Highest grade completed: ______________

Any difficulty learning to:

Read:____________________________________________

Write: ____________________________________________

Math: ____________________________________________

Did you ever repeat a grade? Yes or No

For what reason: ____________________________________________

____________________________________________

Favorite subject: ______________________________

Most accomplished subject:______________________________

Describe any difficulties client is having related to their education: ______________________
____________________________________________
____________________________________________
____________________________________________

Strengths and Interests:____________________________________________
____________________________________________
____________________________________________

What do you enjoy doing the most? ____________________________________________
____________________________________________

What do you do well? ____________________________________________
____________________________________________

Circle all the following that best describe you:

| | | | | | | |
|---|---|---|---|---|---|---|
| *Artistic* | *Athletic* | *Organized* | *Smart* | *Happy* | *Healthy* | *Fun to be around* |
| *Polite* | *Thoughtful* | *Kind* | *Likes Animals* | *Hard Worker* | *Completes Work* | *Musical* |
| *Loving* | *Strong* | *Funny* | *Confident* | *Creative* | *Mathematical* | *Social* |

## Social Relationships

How frequently do you spend time with friends?______________________________________________

How often do you spend time with extended family? ______________________________________

What kinds of activities do you do when you get together? _________________________________

On a scale of 1-10, 10 being very satisfied:

Rate your satisfaction with peer relationships: 1 2 3 4 5 6 7 8 9 10

Rate your satisfaction with extended family relationships: 1 2 3 4 5 6 7 8 9 10

Who do you feel is "on your side" in life?_________________________________________________

__________________________________________________________________________________

Are there any people in your life you can talk to about your problems?_________________________

__________________________________________________________________________________

Please describe any difficulties you are having with friends or family:__________________________

__________________________________________________________________________________

__________________________________________________________________________________

Family History (Please list those family members with history of mental illness, learning disabilities, intellectual developmental disability, or addictions) (If you need more space use back)

Parents: ___________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Siblings:___________________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Maternal Grandparents: _____________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

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Paternal Grandparents: ____________________

## Sleep

Current Hours ____________________

Typical Hours of Sleep ____________________

## Appetite

Describe current changes in appetite: ____________________

## Mental Health History

(Past outpatient services and hospitalizations, include dates)

____________________

What was your diagnosis (es)? ____________________

How did it help? ____________________

Have you ever experienced suicidal/homicidal ideations? Yes or No

Intentions? Yes or No

If yes, please explain: ____________________

Are you willing to sign a release of information for previous mental health providers? Yes or No

Primary Care Giver is (Circle One): Biological Parent Adoptive Parent Foster Parent Other

Primary Care Giver is (Circle One): Married Single Divorced Widowed Other

Name siblings and ages: ____________________

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## Legal Issues:

(List any past & present legal issues: i.e., arrests, convictions, etc. include dates)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Abuse History

(has client been victim of any type of abuse?):

Physical Abuse: Yes or No If Yes Age at time of abuse: ______________

Emotional Abuse: Yes or No If Yes Age at time of abuse: ______________

Sexual Abuse: Yes or No If Yes Age at time of abuse: ______________

Domestic Violence: Yes or No If Yes Age at time of abuse: ______________

Abandonment: Yes or No If Yes Age at time of abuse: ______________

Neglect: Yes or No If Yes Age at time of abuse: ______________

Treatment received for abuse: ____________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Who was perpetrator? ____________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Reported to Authorities? _________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Finding/disposition: ______________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Did client witness any types of abuse listed above: Yes or No

If yes, which type of abuse? _______________________________________________
______________________________________________________________________________
______________________________________________________________________________

Who was the victim? ______________________________________________________

Who was the perpetrator? ____________________

Has client been the perpetrator of any abuse? Yes or No

If yes, which type of abuse? ____________________

____________________

Who was the victim? ____________________

## Substance Use History

(If you need more space use back of page)

| Substance | Yes | No | Substance | Yes | No | Substance | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Alcohol | | | Pain Pills | | | Marijuana | | |
| Tranquilizers | | | Stimulants | | | Inhalants | | |
| Sleeping Pills | | | Narcotics | | | Food | | |
| Hallucinogens | | | Heroin | | | Sex | | |
| Tobacco | | | Meth | | | Other | | |

If other, please list: ____________________

____________________

Drug of preference: ____________________

How long used? ____________________ Last used? ____________________

Treatment program: ____________________

When? ____________________

How long? ____________________

How long clean/sober? ____________________

## Medical History (If you need more space use back of page):

List any major accidents, illnesses, operations with date of occurrence: ____________________

____________________

____________________

____________________

____________________

____________________

____________________

____________________

____________________

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List current medications and reason prescribed:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

## Goals for Counseling:

*What three things would you like to change by participating in counseling*?

1. ______________________________________________________________
   ______________________________________________________________
2. ______________________________________________________________
   ______________________________________________________________
3. ______________________________________________________________
   ______________________________________________________________

*How long do you think it will take to make these changes*? ______________________________
______________________________________________________________________
______________________________________________________________________

*What do you think it will require on your part to make these changes*? ______________________
______________________________________________________________________
______________________________________________________________________

*How will you know when you have accomplished your goals for counseling*? ________________
______________________________________________________________________
______________________________________________________________________

*What else do you think is important for your counselor to know about you*? _______________
______________________________________________________________________
______________________________________________________________________

## Emergency Contact:

Who do you want contacted in case of an emergency?

Name:_______________________________________________

Phone number: ________________________________________

Relationship: _________________________________________

Client Signature: ______________________________________________ Date: __________________

Primary Caregiver's signature: ____________________________________ Date: __________________