Individual Minor Intake Form

Child/Adolescent Information
Name: _____ DOB: _____
Address: _____
City/State/Zip Code: _____

Parent/Legal Guardian A: Personal Information
Name: _____ DOB:_____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of ID or Drivers License ▢

Parent/Legal Guardian B: Personal Information
Name: _____ DOB: _____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____
Copy of ID or Drivers License ▢

Step Parent or Guardian of Child Personal Information
Name: _____ DOB: _____
Address: _____
City/State/Zip Code: _____
Phone (H): _____ Phone (cell): _____
Email: _____ OK to contact via email? _____
Employer: _____ Phone (W): _____

Referral Source:
If referred, name of group or person that referred you to counseling: _____
Were you referred directly to The Vine Wellness for counseling? ( ) Yes ( ) No

Annual household income(optional): _____ Currently meeting your bills? ( ) Yes ( ) No

Family Information

People living in the home:

Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____
Name: _____ Age: _____ Relationship: _____

What languages are spoken in the home? _____
How many homes does the minor client currently occupy? _____
Please describe the minor client's current room/sleeping arrangement: _____
Who has legal custody and conservatorship of the minor client? _____

Relationship Status of the Parent/Legal Guardian filling this out:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Widowed How long? _____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
In what year were the parents separated, if applicable? _____

Minor Client's History

What is the minor's approach to new situations? ____ Positive ___ Withdrawn ____ Slow to warm up
When trying new things would you describe the minor as:
____ Adaptable ____ Slow to adapt ___ Unadaptable
How is the minor client disciplined in the home? _____
Any current troubles with sleeping? _____
Did/does the minor co-sleep with anyone in the home, if so with who?_____
Does the minor client have any current speech, hearing, or language difficulties? _____
_____
List all childhood illnesses, hospitalizations, head injuries, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other medical conditions:
_____
_____
_____

Special skills and talents of child:
List hobbies, sports; recreational, musical, TV and toy preferences; etc.: _____
_____
_____

Education Information

Name of current school or describe if homeschooled: _____
Academic Grade Level: _____
On-Site Schooling or Virtual Schooling? _____
Name of teacher(s): _____
How many schools has the minor client attended in the last 2 years? _____

Describe the minor client's academic performance over the past school year: _____

_____

_____

Is the minor client's behavior a problem in school? _____

Do they receive Special Education services? _____

If applicable, date of last ARD (Admission, Review, Dismissal): _____

Current Health Information

List any chronic illnesses, genetic illnesses, allergies or ways in which the minor client may be differently-abled: _____

_____

Is your child currently being treated for any illnesses or medical problems? ( ) Yes ( ) No What type?

_____

_____

Is your child taking any medications at this time? ( ) Yes ( ) No

List ALL current prescription medications and how often the minor client takes them (to your knowledge):

If none, write none

Medication Name Total Daily Dosage Estimated Start Date

_____

_____

_____

Current over-the-counter medications or supplements:

_____

_____

Date and place of your child's last yearly check-up: _____

Current Physician: _____ Phone: _____

<u>Family Psychiatric History:</u>

Has anyone in your child's family been diagnosed with or treated for: (Do we want this to look the way it does on the adult one?)

Bipolar disorder ----------( )Yes ( )No
Depression ----------( )Yes ( )No
Anxiety ----------( )Yes ( )No
Anger ----------( )Yes ( )No
Suicide----------( )Yes ( )No
Schizophrenia ----------( )Yes ( )No
Post-traumatic stress ----------( )Yes ( )No
Alcohol use ----------( )Yes ( )No
Other substance abuse----------( )Yes ( )No
Violence----------( )Yes ( )No

If yes, who had each problem?

_____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No

If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Has a relative ever been **hospitalized** for drug or alcohol use, or mental or emotional difficulties?

_____

Child's Psychiatric History:

Has your child participated in counseling in the past? ( ) Yes ( ) No
Is your child currently involved in any other counseling, including lay counseling, spiritual counseling, counseling at school, and/or professional counseling? ( ) Yes ( ) No
Current or past mental health diagnoses, date of diagnosis and by whom:

_____
_____

Intensive outpatient treatment? ( ) Yes ( ) No If so, When: _____
Where? _____

Psychiatric Hospitalizations? ( ) Yes ( ) No If so, When: _____
Where? _____

Drug and Alcohol Treatment/hospitalizations? ( ) Yes ( ) No If so, When : _____
Where? _____

Caffeine Usage:

How many caffeinated beverages do you drink a day?
Coffee _____ Sodas _____ Tea _____ Energy Drinks _____

Tobacco History:

Has your child ever smoked cigarettes/E-Cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No If so, How often: _____
Has your child used chewing tobacco? ( ) Yes ( ) No

Alcohol and/or drug use:

Does your child drink alcohol? ( ) Yes ( ) No
If Yes, how often? _____

Extra-curricular Activities/ Exercise:

Does your child exercise regularly? ( ) Yes ( ) No
Is your child currently involved in any organized groups/ individual lessons? ( ) Yes ( ) No
If Yes, please list: _____

Trauma History:

Has there been any significant changes in your child's life in the past 18 months? ( ) Yes ( ) No
If yes, explain: _____
_____
Are you aware if your child has ever experienced any form of abuse: emotional, sexual, physical or by neglect? ( ) Yes ( ) No
If Yes, please describe when, where, by whom and if a CPS report was made _____
_____
_____
_____
_____
_____

Spiritual Life:

Does your child belong to a particular religion or spiritual group? ( ) Yes ( ) No

Name of congregation: _____

If yes, what is the level of your child's involvement?

_____

Do you find your child's involvement helpful during this time, or does the involvement make things more difficult or stressful for them? ( ) more helpful ( ) stressful

Mental Status Information

Has your child made any recent comments about suicide, not wanting to be around any more, or comments/signs of harming themselves in any way?

( ) Yes ( ) No

Has your child had any thoughts/comments, even once, in the past, including the past few days or weeks, of suicide or harming themselves in any way? ( ) Yes ( ) No

Has your child made comments about harming anyone else in any way? ( ) Yes ( ) No

Counseling Information

Describe the situation that brings you to seek counseling for your child: _____

_____

_____

_____

Describe what has already been done to resolve the situation: _____

_____

_____

_____

What do you hope for in resolving the situation? What will be different? _____

_____

_____

_____

Is there anything else that doesn't appear on this or other forms, but that is or might be important?

_____

_____

_____