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Minor Intake Form

Date: _____

Child's Name: _____ Child's Parental Guardian: _____

Address:_____

Phone Numbers:
_____

Email:_____

What is happening in your child's life, which resulted in this appointment?
_____
_____
_____
_____
_____

What is your top source of stress in the family:

Spouse ☐ Children ☐ My Job ☐ Financial ☐ Illness ☐ Friendships ☐ Other ☐

The second top source of stress is:

Spouse ☐ Children ☐ My Job ☐ Financial Illness ☐ Friendships ☐ Other ☐

The third top source of stress is:

Spouse ☐ Children ☐ My Job ☐ Financial Illness ☐ Friendships ☐ Other ☐

Does your child experience any of the following symptoms?

Depression	Feelings of Worthlessness	Sadness/Loss	Low Energy	Sleep Disturbance (more/less)
Self-Harming Behavior	Appetite Disturbance (more/less)	Low Self-Esteem	Thoughts of hurting yourself or past suicide attempts	Excessive Guilt

Does your child experience any of the following symptoms?

Excessive Worry	Unpleasant Thoughts Won't Go Away	Restlessness	Irritability	Mind Going Blank
Feeling Like You Can't Turn Off Your Brain or You Can Relax	Exposure to a Traumatic Event	Victim of Child Abuse	Re-experiencing of Traumatic Event (nightmares, flashbacks, etc)	Avoidance of People, Places, or Things Related to the Trauma Event
Intrusive Thoughts	Muscle Tension	Distractibility	Excessive Fears	Compulsive Behaviors

Have you or your child recently experienced any of the following?

A Stressor You've Had to Adjust To	The Loss of A Loved One	Relationship Conflict	Separation/Divorce	Victim of a Crime

Has your child been previously diagnosed with any conditions?
NONE ---- Other ----

_____

Is your child on any kind of medications?
NONE ----- Other ----

_____

Is there any current or previous addiction to any substances in the family?
NONE ---- Other ----

_____

What would you like to see accomplished in therapy?

_____
_____
_____

What would you like to see your child accomplish in therapy?

_____
_____
_____

Are you open to family therapy if needed?

_____
_____
_____