Positive Changes Counseling Center, Debbie Disney, LCSW-C, LLC

New Client Intake Form: Child, Under 18 Years Old

Please fill out the form below and bring to your first session.
Please note: the information you provide here is protected as confidential information.

Name: ____
(Last) (First) (Middle Initial)

Name of parent/guardian:

____
(Last) (First) (Middle Initial)

Birth Date of Client: ______/_______/________ Age: ________ Gender: _____________

Insurance type (Aetna, BCBS, Cigna, etc.): ____________________________________

Name of Primary Insurance Policy Holder: ____________________________________

Birth Date of Insurance Policy Holder: ________/_________/_________

Address: ____
(Street and Number)

____
(City) (State) (Zip Code)

Cell Phone: ( ) May we leave a message? ____Yes ____ No

May we leave a text message on your cell phone? ____Yes ____ No

Email: ____

May we email you? ____Yes ____ No

***Please note: Email correspondence and text messaging are not considered to be confidential mediums of communication.**

How did you find us? ____

Family History:

Parents

With whom does the child live with? ____

Are parents divorced or separated? ____

If yes, what is the legal custody agreement? ____

Were the child's parents ever married? ____Yes ____ No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ____Yes ____ No

If yes, please describe (use back of this sheet if needed):
____

____

Siblings and Others who live in the household:

Name of Siblings/Others	Age	Gender	Lives
______________________	____	____F ____M	__Home __Away
______________________	____	____F ____M	__Home __Away
______________________	____	____F ____M	__Home __Away
______________________	____	____F ____M	__Home __Away

Comments: ____
____
____

Family Mental Health History:

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (ex. Maternal grandmother, father, paternal grandfather, etc.)

	Please Circle:	Family Member(s):
ADHD/ADD	Yes / No	________________________
Alcohol/Substance Abuse	Yes / No	________________________

Anxiety	Yes / No	________________________
Depression	Yes / No	________________________
Domestic Violence	Yes / No	________________________
Eating Disorders	Yes / No	________________________
Disordered Eating	Yes / No	________________________
Obsessive Compulsive Behavior	Yes / No	________________________
Mental Illness	Yes / No	________________________
Suicide	Yes / No	________________________
Other: __________________	Yes / No	________________________

Education:

Current school: ____

Grade: ___________________

Have there been any recent changes in the child's academics? ____ Yes ____ No

If yes, please explain: ____

Has the child had any educational or psychological testing? ____Yes ____ No

If yes, please explain: ____

Was there a formal diagnosis? ____Yes ____ No

If yes, please explain: ____

Has the child received a formal education intervention or accommodations (IEP, 504, etc.)?
____Yes ____ No

If yes, please explain: ____

Feelings about school (check all that apply):

____ Anxious ___ Passive ___ Enthusiastic ___ Fearful

____ Eager ___ No Expression ___ Bored ___ Rebellious

___ Other (please describe): ____

General Health and Mental Health Information:

Name of Primary Care Provider: ____

Have you previously received any type of mental health services (psychotherapy, psychiatrist services, etc.)? ____ Yes ____ No

If yes, please list previous therapist/practitioner: ____

Have you ever been prescribed psychiatric medication? ____ Yes ____ No

If yes, please list and provide dates you were first prescribed: ____________________________

____

Are you currently taking any prescription medication? ____ Yes ____ No

If yes, please list: ____

Name of Psychiatrist or Medical Practitioner: ____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing: ______________________
____
____

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing: ______________________
____
____

Do you regularly exercise? ____ Yes ____ No
If yes, about how many times per week and what type of exercise do you partake in?
____
____

Do you struggle with food?

____

____

____

Are you experiencing sadness, grief, or depression? ____ Yes ____ No

If yes, for approximately how long? ____

Please explain: ____

____

Are you experiencing anxiety, anxiety attacks, or panic attacks? ____ Yes ____ No

____

Please explain: ____

Do you have any phobias? ____ Yes ____ No

Please explain: ____

Are you experiencing chronic pain? ____ Yes ____ No

If yes, please explain: ____

____

Is there a history of self- harm ____ Yes ____ No Suicidal thoughts ____ Yes ____ No

Have you experienced any significant life changes or stressful events?

____

____

____

____

What activities do you enjoy?

____

____

What do you consider to be your strengths?

____

____

What do you consider to be your weaknesses?

____

____

Please describe the main difficulties or concerns that have brought you to therapy.

____

____

____

____

What are your goals for therapy?

____

____

____

____

Is there anything else you would like me to know about you that is not on this form?

____

____

____

____