COUNSELING INTAKE FORM – CHILD/ADOLESCENT

Mayfield Counseling Centers asks that you complete this form to the best of your ability. It is intended for use by clients under the age of 15, as well as those ages 15-17 who are being presented by their parent(s) for counseling. There are separate sections for the parent/guardian and the minor child to complete, as able. While you are not required to supply the information requested, know that the more you share, the better we are able to meet your specific needs. This information may be considered confidential; however, certain otherwise confidential information may be shared as required by law. The completed intake form will be kept in the client file and maintained under the same confidentiality protections as the therapeutic record, as detailed in the Mayfield Counseling Centers Disclosure Statement and HIPAA Form.

Parent/Guardian Section – Pages 1-10

Demographics & Contact Information

____ ____________________
Client Name Date of Birth

_______ ________________________ Gender: □ Male □ Female □ Other: ____________
Age Ethnicity

____
Street Address, City, State, Zip

____ ____________________
Mother Name Mother Phone

____
Street Address, City, State, Zip

____ ____________________
Father Name Father Phone

____
Street Address, City, State, Zip

____ ____________________
Legal Guardian Name Guardian Phone

____
Street Address, City, State, Zip

____ ____________________
Emergency Point of Contact (POC) Emergency POC Phone

____
Relationship to Client

Client Mobile Phone: _______________________________ OK *to leave a message?* ***Y or N***

Client Home Phone: ________________________________ OK *to leave a message?* ***Y or N***

Email: ____ OK *to email you?* ***Y or N***

See the Mayfield Counseling Centers HIPAA and Notice of Privacy Policies and Consent for Communication by Non-Secure Transmission form before agreeing to receive communication via electronic means.

Minor Child lives with: (Please check all that apply)

☐ Father ☐ Mother ☐ Both Biological Parents ☐ Both Legally Adoptive Parents

☐ Stepfather ☐ Stepmother ☐ Relatives: ____

☐ Other: ____

In the case of divorced parents, who has legal custody of the minor child? _____________________

____

☐ ***Therapist: Obtain a copy of the custody agreement/order.***

Who else lives in the home (siblings, relatives, significant others, etc.)? _______________________

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Persons present for the intake session: ____

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☐ ***Therapist: Confirm that this person is the parent or legal guardian***

____ ____________________
Physician Name Phone

____ ____________________
Phychiatrist/Prescriber Name Phone

____ ____________________
Previous Counselor Name Phone

Please note that in accordance with applicable HIPAA and Colorado regulations, we will not contact your physician, psychiatrist, or counselor without your knowledge and consent.

Is <u>the minor child's</u> primary insurance Medicaid? *Y or N*

Mother Employment Status: *FT PT Student Unemployed Not Desiring Outside Employment*

Employer: ____

Health Insurer: ____________________________ Is your primary insurance Medicaid? ***Y or N***

Household Annual Income: _________ *A reduced fee application is available; ask your therapist.*

Father Employment Status: *FT PT Student Unemployed Not Desiring Outside Employment*

Employer: ____

Health Insurer: ____________________________ Is your primary insurance Medicaid? ***Y or N***

Household Annual Income: _________ *A reduced fee application is available; ask your therapist.*

Guardian Employment Status: *FT PT Student Unemployed Not Desiring Outside Employment*

Employer: ____

Health Insurer: ____________________________ Is your primary insurance Medicaid? ***Y or N***

Household Annual Income: _________ *A reduced fee application is available; ask your therapist.*

How did you hear about Mayfield Counseling Centers? __________________________________

____

What led you to seek counseling for your minor child? ____
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How long has this been a significant problem for your child? ____________________________________
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Please describe any incidents or situations that may have contributed to this issue (e.g. school, trauma, divorce, relationships, etc.): ____
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____

In the past, what has been helpful to your child in dealing with this issue? ________________________
____
____
____
____

Please describe your child's strengths, weaknesses, general behavior, and attitude: _________________
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____

Among your child's friends and family, who provides support (emotional, spiritual, financial, etc.)?

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What part does faith, religion, or spirituality play in your family's life? ________________________

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Do you attend a place of worship? ☐ YES ☐ NO If so, where? __________________________

Harm to Self or Others

Has your child had thoughts of harming him/herself or others? ☐ YES ☐ NO If yes, please explain:

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____

Has your child ever seriously considered suicide or attempted suicide? ☐ YES ☐ NO If yes, explain:

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____

Does your child have the intent and means to commit suicide now? ☐ YES ☐ NO If yes, explain:

____

____

Does your child have the intent and means to harm or kill someone other than him/herself right now?
☐ YES ☐ NO If yes, explain: ____

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Medical and Mental Health History

Is your child experiencing any physical symptoms such as over/under eating, sleeping problems, chest pain, anxiety, depression, shortness of breath, etc.? ☐ YES ☐ NO If yes, please explain:

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Are there any significant past or present **health or medical** issues that we should be aware of? ☐ YES ☐ NO If yes, please explain: ____

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Are there any significant past or present **mental health** issues that we should be aware of? ☐ YES ☐ NO If yes, please explain: ____

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Are there any significant past or present **developmental** issues that we should be aware of? ☐ YES ☐ NO If yes, please explain: ____

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Has your child ever experienced **abuse** (emotional, physical, and/or sexual)? ☐ YES ☐ NO

If yes, please describe, to include dates and relationship of the abuser: ___________________________

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Has your child experienced other types of **trauma**, to include concussion? ☐ YES ☐ NO

If yes, please describe: ____

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Has your child experienced **flashbacks** concerning trauma**?** ☐ YES ☐ NO If yes, please describe:

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Medication, Substance Use, and Addiction

Please list all medications your child is now taking and/or has taken <u>in the past 3 months</u>:

Medication:	***Dosage:***	***Prescriber:***	***How long?***	***Helpful?***	***Reason/Comments:***

Please indicate whether your child uses (or has used in the past) the following substances:

Tobacco:	☐ YES ☐ NO	Starting age/extent:	______________________
Marijuana:	☐ YES ☐ NO	Starting age/extent:	______________________
Drugs:	☐ YES ☐ NO	Starting age/extent:	______________________
		Drug(s) of choice:	______________________
Alcohol:	☐ YES ☐ NO	Drinks per week:	______________________
		Drink(s) of choice:	______________________
Other:	☐ YES ☐ NO	Starting age/extent:	______________________
		Substance(s) of choice:	______________________

Does your child have other addictions, such as food, gaming, shopping, porn, etc.? ☐ YES ☐ NO

If yes, please explain: ____

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Has your child been in any substance/process addiction treatment programs? ☐ YES ☐ NO

If yes, please explain: ____

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Family of Origin Questions

Describe your child's immediate family (e.g. parents, siblings, ages, etc.): ____________________

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Does your child's family, whether biological or adopted, struggle with mental illness, chemical dependency, suicidality, etc.? ☐ YES ☐ NO If yes, please explain: ____________________

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Other Questions

Does your child have a preoccupation with weapons? ☐ YES ☐ NO If yes, please explain:

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Are there weapons unlocked/accessible in the home? ☐ YES ☐ NO If yes, please describe:

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Are there incidents of fire setting in your child's history? ☐ YES ☐ NO If yes, please describe:

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Are there incidents of animal abuse in your child's history? ☐ YES ☐ NO If yes, please describe:

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Please describe your child's friends: ____
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What else would you like us to know about your child? Consider changes in behavior; relationships, hobbies, interests, activities, socialization, etc.: ____
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____
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____
____

Parent/Guardian Signatures

____
Parent/Guardian #1 Printed Name

____ ____________________
Parent/Guardian #1 Signature Date

____
Parent/Guardian #2 Printed Name

____ ____________________
Parent/Guardian #2 Signature Date

____
Therapist Printed Name, Credentials

____ ____________________
Therapist Signature Date
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Child/Adolescent Section – Pages 11-20

<u>Note: For adolescents presenting themselves for counseling (without parent involvement), please also complete pages 1-3 of the parent/guardian section</u>

Current Concerns

What brings you in today? What do you hope to accomplish in counseling? ______________________

____

____

____

How long has this been a significant problem for you? ____

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In the past, what has been helpful for you in dealing with this issue? ___________________________

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How do you describe yourself? What are some of your strengths and weaknesses? ________________

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What do you like to do for fun? What are you good at? ______________________________________

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Home Environment

Describe the relationships and communication within your home: ______________________________

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Do you feel safe at home? ☐ YES ☐ NO Please explain: ________________________________

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Do you have rules at home such as limits on amounts of TV you can watch, doing your homework, chores, curfew, etc.? ☐ YES ☐ NO Please describe: ____________________________________

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What consequences do you typically face if/when you don't follow the rules? ____________________

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What are some things you do as a family? ____

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Have you, as a family or personally, experienced any significant family events, traumas, or major changes? ☐ YES ☐ NO Please explain: ____

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Is there any history of abuse in your life? This can be physical, mental, emotional, sexual, or even spiritual. ☐ YES ☐ NO Please describe, to include your age at the time, relationship to abuser, etc:

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Do you ever have flashbacks of the abuse? ☐ YES ☐ NO Please describe: _________________

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What are your family's strengths? What are your family's weaknesses? __________________________

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What adult do you connect with the best? Name: ____

Describe your relationship, and the things you do together: ________________________________

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Have you ever tried to run away from home, or thought seriously about running away?

☐ YES ☐ NO Please describe: ____

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____

Have you ever lived anywhere other than with your family at home? ☐ YES ☐ NO Please explain:

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School, Work, Social & Community Involvement

Name of School: ____ Grade: __________________

On Grade Level? ☐ YES ☐ NO Type of Curriculum: ___________________________________

Describe your relationships with teachers, administrators, and other school authority figures:

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Have you ever been suspended, expelled, or disciplined at school? ☐ YES ☐ NO Please describe:

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Have you ever been in a fight or similar altercation at school? ☐ YES ☐ NO Please describe:

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Is there at teacher, counselor, coach, or other adult you can talk to? ☐ YES ☐ NO Please describe:

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____

Do you go to any youth groups, church groups, or other clubs? ☐ YES ☐ NO Please describe:

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Describe your relationships with classmates and other peers at school, clubs, etc.: _______________

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Do you have a girlfriend or boyfriend? ☐ YES ☐ NO How long have you been together? Is there violence in the relationship? Is your relationship sexual? Describe: _____________________

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Do you have children? ☐ YES ☐ NO Have you/your girlfriend had an abortion? ☐ YES ☐ NO

Describe: ____

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____

Have you ever had a job? ☐ YES ☐ NO Please describe: _____________________________

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Medical History

Do you take, or have you ever taken medications? ☐ YES ☐ NO Please describe: __________

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Do you have any chronic illnesses? ☐ YES ☐ NO Please describe: ______________________

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Have you experienced significant injuries, concussions, or car accidents? ☐ YES ☐ NO Describe:

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Have you ever been hospitalized? ☐ YES ☐ NO Please describe: ________________________

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Have you ever received any psychological or counseling services before? ☐ YES ☐ NO Describe:

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Have you ever wanted to end your life or desired to hurt yourself? ☐ YES ☐ NO Please describe:

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Have you ever attempted suicide or tried to hurt yourself? ☐ YES ☐ NO Please describe:
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____

Do you have the intent and means to commit suicide now? ☐ YES ☐ NO If yes, explain:
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____

Do you have the intent and means to harm or kill someone other than yourself right now? ☐ YES ☐ NO If yes, explain: ____
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____

Do you engage in cutting, restricting food, or other forms of self-harm? ☐ YES ☐ NO Describe:
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Do you have a history of sleeping or eating problems? ☐ YES ☐ NO Please describe:
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Have you ever had any auditory or visual hallucinations? ☐ YES ☐ NO Please describe:
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Would you describe yourself as sad or anxious? ☐ YES ☐ NO Please describe:
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____
____

Please indicate whether you use (or have used in the past) the following substances:

Tobacco:	☐ YES ☐ NO	Starting age/extent:	______________________
Marijuana:	☐ YES ☐ NO	Starting age/extent:	______________________
Drugs:	☐ YES ☐ NO	Starting age/extent:	______________________
		Drug(s) of choice:	______________________
Alcohol:	☐ YES ☐ NO	Drinks per week:	______________________
		Drink(s) of choice:	______________________
Other:	☐ YES ☐ NO	Starting age/extent:	______________________
		Substance(s) of choice:	______________________

Do you have other addictions, such as eating, gaming, shopping, porn, etc.? ☐ YES ☐ NO

If yes, please explain: ____
____
____
____

Have you been in any substance/process addiction treatment programs? ☐ YES ☐ NO

If yes, please explain: ____
____
____
____

Sentence Completion

I came here today ____

I am really happy when ____

I feel mad when ____

I feel sad when ____

I love ____

I hate ____

I wish ____

Growing up in my family ____

If I could change one thing ____

Six months from now ____

Additional Questions

What are some of your short-term goals? (within the next month) ______________________________

____

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____

What are some of your longer-term goals? (within the next year and beyond) ____________________

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____

If you have had therapy before, what worked best for you? What would you have changed?

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____

How will you know that therapy has been a success? ____
____
____
____

What do you want life to look like upon the completion of therapy? ____________________________
____
____
____

Is there anything else we need to know to better assist you? ___________________________________
____
____
____
____
____

Signatures

____
Client Printed Name

____ ______________________
Client Signature Date

____
Therapist Printed Name, Credentials

____ ______________________
Therapist Signature Date
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