CHAMPIONS COUNSELING CENTER

Minor Intake Form

Client Name: ________________________________ Today's Date: _____________________

Date of Birth: _____________________ Age: __________

PRESENTING PROBLEMS AND CONCERNS

1) Describe the problems that brought you here today:

2) Please check all your child's behaviors and symptoms that you consider problematic:

Distractibility	Change in appetite	Visual hallucinations
Manipulative behavior	Hyperactivity	Withdrawal from people
Defiance	No/few friends	Impulsivity
Anxiety/Worry	Aggression/fights	Eating problems
Boredom	Panic attacks	Homicidal thoughts
Sleep problems	Poor memory/confusion	Fear away from home
Frequent arguments	Nightmares	Sadness/depression
Social discomfort	Irritability/anger	Toileting problems
Hopelessness	Phobias	Peer/sibling conflict
Fire setting	Thoughts of death	Obsessive thoughts
Stealing	School problems	Self-harm behaviors
Compulsive behaviors	Destroys property	Legal problems
Crying spells	Racing thoughts	Running away
Sexual behavior	Loneliness	Wide mood swings
Swearing	Computer/video addiction	Low self-worth
Suspicion/paranoia	Curfew violations	Alcohol/drug use
Fatigue	Hearing voices	Lying
Lack of motivation	Recurring, disturbing memories	
Other:		

3) Are your child's problems affecting any of the following?

Handling everyday tasks	Self-esteem	Relationships
Hygiene	Health	Recreational activities
School work	Housing	**L**egal matters
Finances		

4) Has your child ever had thoughts, made statements, or attempted to hurt him/herself?
   Yes No If yes, please describe:

5) Has your child ever had thoughts, made statements, or attempted to hurt someone else?
   Yes No If yes, please describe:

6) Has your child been physically hurt or threatened by someone else? Yes No
   If yes, please describe:

7) If the answer to questions 1) through 3) is, "Yes", is there a safety plan in place?
   Please Describe:

8) In the past or present, has there been any CPS involvement in your family? Yes No
   If yes, please explain, and provide information about your CPS caseworker, including name, phone number and case number:

   Case Number:
   Caseworker Name: Ph:

9) Other information you would like your child's therapist to know:

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Lives with child?	Age	Quality of Relationship
Mother				
Father				
Stepmother				
Stepfather				
Siblings				
Other Relatives				

MENTAL HEALTH FAMILY HISTORY

Family Mental Health Problems	**Who?**
Hyperactivity/ ADHD Diagnosis	
Sexually Abused	
Depression	
Bipolar	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	
Other:	
Other:	
Other:	
Other:	

10) Are parents legally married or living together? Yes No
11) Are parents temporarily separated? Yes No
12) Are parents divorced or permanently separated? Yes No
 a) If yes, who is the managing conservator? Mom Dad
 b) Mother remarried? Yes No If yes, number of times? ____
 c) Father remarried? Yes No If yes, number of times? ____

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13) Please check if your child has experienced any of the following types of trauma or loss:

Emotional abuse	Neglect	Lived in a foster home
Sexual abuse	Violence in the home	Multiple family moves
Physical abuse	Crime victim	Homelessness
Parent substance abuse	Parent illness	Sibling illness
Loss of a loved one	Teen pregnancy	Adoption
Financial problems	Parent deployed for military service	

14) Any medical problems during the pregnancy or birth of your child? Yes No

If yes, please describe:

15) During pregnancy, did the child's mother use any tobacco, medication, street drugs or alcohol while pregnant with this child? Yes No

If yes, please describe substances used, quantity, and frequency:

16) Was the mother under stress during pregnancy? Yes No

If yes, please describe:

17) Did your child have any developmental delays in early childhood (crawling, walking, talking, toilet training, etc.)? Yes No

If yes, please describe:

PREVIOUS MENTAL HEALTH TREATMENT

Type of Treatment	When Mo./Year	Provider Program	Reason for Treatment
Counseling			
Medication (mental health)			
Psychiatric Hospitalization			
Drug/Alcohol Treatment			
Self-Help/Support Groups			
Other:			

SCHOOL INFORMATION

18) Name of School: Current grade/placement:

a) This year's grades:	Excellent	Good	Fair	Poor
b) Past school grades:	Excellent	Good	Fair	Poor
c) This year's school behavior:	Excellent	Good	Fair	Poor
d) Past school behavior:	Excellent	Good	Fair	Poor

19) Has your child had any of the following difficulties at school?

Suspension	Incomplete homework	Learning problems
Referrals or detention	Poor grades	Teased or picked on
Speech problems	Attendance problems	Problems with teacher
Gang influence	Other:	

a) If any items were checked above, please describe what steps were taken to rectify the problem:

20) Does your child have a before or after school provider? Yes No
If so, who cares for your child?

21) Has your child ever skipped or repeated a grade? Yes No
If yes, which grade(s)?

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22) Has your child ever received Special Education Services? Yes No
If yes, please describe services received and reason for services:

23) What does your child's teacher(s) say about him/her?

MEDICAL INFORMATION

24) Pediatrician: Phone:
25) Date of last physical exam:

26) Has your child experienced any of the following medical conditions during his/her lifetime?

Allergies	**A**sthma	Headaches	**S**tomach aches
Chronic pain	Surgery	Serious accident	Head injury
Meningitis	Vision problems	Seizures	Dizziness/fainting
High fevers	Diabetes	Ear infections	Hearing problems
Genetic disorder	Sleep disorder	Other: ________________________	

27) Please list any CURRENT health concerns:

28) Is your child currently taking any prescription medications: Yes No

Medication	Dosage	Date prescribed	Prescribed by

29) Current over-the-counter medications (including vitamins, herbal remedies, etc.):

30) Allergies and/or adverse reactions to medications: Yes No If yes, please list:

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

31) Please describe your child's social support network (check all that apply):

Family	Neighbors	Friends
Teachers	School Staff	Community Group
Classmates	Support/Self-Help Group	Church/Religious Group

32) To which cultural or ethnic group does your child belong?

33) Is your child experiencing any difficulties due to cultural or ethnic issues? Yes No
If yes, please describe:

34) How important are spiritual matters to your child?

Not at all A little bit Somewhat Very much

35) Would you like spiritual/religious beliefs incorporated into your child's counseling?
Yes No

36) Please describe your child's strengths, skills, and talents:

37) Please describe any special areas of interest or hobbies your child has:

38) Does your child participate in extracurricular activities, groups, or team sports?
Yes No If yes, please list:

41) How many times per week does your whole family eat a meal together?

0 1 2 3 4 5 6 7 8 or more

42) How many hours per week does your child spend on a screen?
(include computer, tablet, gaming, smart phone)

0-3 4-7 8-10 11-15 15 or more

43) What are some things you enjoy doing as a family?

44) Is there anything else you would like your child's therapist to know about your child?

45) What are you hoping your child gains from therapy?

46) Are you interested in receiving?

Individual Counseling Couples Counseling Family Counseling

Parenting Classes Parental Support

Other:

47) Who may we thank for this referral?

______________________________ ______________________________
Name of person completing form Relationship to client

______________________________ ______________________________
Signature Date