Sacred Tree Counseling, LLC

Child/Minor Client Intake Form

Please answer all questions. Use the back for additional information if necessary. You will have a chance to explain any answers during our intake session.

Child's Name: _____ Today's date: _____

Nickname of child: _____

Birth Date: _____ Age: _____ Gender: _____

School: _____ Grade: ____ Teacher: _____ Counselor: _____

Parent/Guardian (1):	Parent/Guardian (2):
Address:	Address:
City:	City:
Zip Code:	Zip Code:
Preferred Phone:	Preferred Phone:
Messages okay?: □ Yes □ No	Messages okay?: □ Yes □ No
Email Address:	Email Address:

Marital status of child's parents/guardians: (Please include the timing of any death/divorce/separation or union):

_____

_____

Living Arrangement? (Check Which Apply)

□ Both Parents □ One Parent □ Custody Arrangement □ Guardian □Other, please list:

_____

Pertinent details of living arrangement: _____

Please list all family members or other people living in the child's home:

Name	Age	Gender	Relationship to Child

Please list all other family or important people in your child's life:

Name	Age	Gender	Relationship to Child

Medical Information

Current Medical Conditions: _____

Medications or Treatments: _____

Physician Name: _____ City: _____ Phone: _____

Emergency Contacts (please list name and phone numbers):

1. _____
2. _____
3. _____

Who is approved to bring/pick up your child from therapy? (include names, phone number, make and model of car)

1. _____
2. _____
3. _____

Has your child been in therapy before? □ Yes □ No

Therapist's Name	Dates	Reason	Outcome

Have other family members been in therapy before? □ Yes □ No

Therapist's Name	Dates	Reason	Outcome

Has your child ever had thoughts of wanting to hurt or kill themselves? Y or **N**
If yes, please answer the following questions:
Are you feeling like you want to hurt or kill yourself right now? **Y** or **N**
When was the last time you thought about hurting or killing yourself? _____
Do you have a plan? **Y** or **N**

Has your child ever had thoughts of wanting to hurt or kill anyone else? Y or **N**
If yes, please answer the following questions:
Are you feeling like you want to hurt or kill anyone right now? **Y** or **N**
When was the last time you thought about hurting or killing someone? _____
Do you have a plan? **Y** or **N**

Is there a known family history for any of the following? (Circle all that apply)

Sexual abuse	Physical abuse	Emotional abuse	Rape	Alcoholism/drugs
Violence	Sleep disorders	Eating disorder	Physical conditions	Mental health history

Please describe reason(s) for seeking therapy at this time:
_____
_____
_____
_____
_____

Please circle any of the following that pertain to your child:

Nervousness	Loss of Interest	Day Defecation
Shyness	Fatigue	Hyperactivity
Loneliness	Day Wetting	Obsesses
Fears	Hypervigilace	School Problems
Separation	Masturbates Excessively	Drug/Alcohol Abuse
Anxiety	Angry/Aggressive	Legal Problems
Startles Easily	Self-Control	Attention/Memory
Stealing	Difficult to Discipline	Difficulty Relaxing
Depression/Sadness	Difficulty with Friends	Lying
Cries Easily	Suicidal	Homicidal
Feeling Inferior	Thoughts/Behaviors	Thoughts/Behaviors

Lack of Empathy	Troubling Thoughts	Divorce
Eating Difficulties	Tantrums	Misplacement
Head/Stomach Aches	Self-Esteem Concerns	Risky Behaviors
Sleep Difficulties	Lack of Interest	Withdrawal/Isolating
Nightmares	Sexualized Behaviors	Hitting/Kicking/Biting

Please list major changes your child and/or your family have experienced during the past five years (e.g. death (people or pets), moves, health changes, family changes, stress, trauma, school or job changes).

_____
_____
_____
_____
_____

Current Family Substance Use (Include alcohol, marijuana, nicotine, prescription and non-prescription drugs):

_____
_____
_____
_____
_____

Are you currently employed? □ Yes □ No

IF yes, where? _____

Religious/Spiritual Affiliation (If Applicable): _____

What do you hope to gain through counseling for your child?

_____

_____

_____

What have you already done to deal with the difficulties?

_____

_____

_____

List any medications and dosages that pertain to mental well-being for your child:

_____

_____

_____

List any other medications and dosages your child currently takes:

_____

_____

_____

What are your child's biggest strengths?

_____

_____

_____

Parent(s)/Guardian(s): _____ Date: _____

Counselor's (signature): _____ Date: _____