## Client Intake (Minor)

**Demographic Information:** *This form is to be completed by the adult responsible for the primary person receiving services. Her/his name should be entered in the space immediately below and the child/adolescent under 18 years of age should be listed under "primary person receiving services."*

**Name:** ______________________________________________________ **Date:**___________________

**Address:** ____________________________________________________________________________

**City:**________________________________________ **State:** __________ **Zip:**____________________

*It is customary practice at Catch23 to mail a letter of termination at the end of treatment. If the above is* ***not*** *a safe or preferred mailing address for you to receive mail, please provide an alternate mailing address here:*

_____________________________________________________________________________________

**Date of Birth:** _______________________ **Social Security:** ___________________________________

**Employer:** ____________________________________ **Occupation:** ____________________________

**Marital Status:** *(Circle One)* Single Married Separated Divorced Widowed Cohabiting

**Spouse/Partner's Name:** ____________________________________ **Date of Birth:** _______________

**If applicable, is the other parent/guardian aware that the minor listed is seeking services from our offices?** *(Yes/No)* _________________ **have they given you consent to bring them?** _________________

**Print** *(Your)* **Name:** ___________________________________________________________________

**Signature:** ____________________________________________________________________________

*In cases of divorce or separation consent to treat from both parents is requested, or copy of parenting plan indicating custody and who is responsible for decision making with regards to health care related decisions.*

**Custody Arrangements:** *(if applicable)*

Primary Residential Parent: ___________________________________________________

Visitation Schedule:

Child is with ___________________ on ______________________

Child is with ___________________ on ______________________

**According to your Parenting Plan, who is authorized to make health care related decisions?** *(Circle)*

Father Mother Joint Other (specify):

_____________________________________________________________________________________

## Client Information

**Primary Person Receiving Services:** ______________________________________________

**Date of Birth:** ____________________**Age:** _______ **Social Security:** ______________________________

**Phone: (H)** ______________________ **(C)** ________________________

**Email:** ___________________________________________________________________________

**Please indicate approved methods of contact:** *(Circle)* **Phone Email Text**

**Gender:** _________________ **Religious Affiliation:** ______________________________________________

**For Students:** *(Circle)* Fr Soph Jr Sr Graduate **Anticipated Graduation:** __________________

**Major/Minor:** ___________________________________________________________________________

**Children:** Yes No

**Referred by**: ___________________________________________________________________________

## Previous Counseling/Performance Coaching:

Previous Sessions? Yes No Who and When? ____________________________________________

Release of information signed to talk with previous counselor/Coach? Yes No

## Medical/Mental Health Information

What, if any, medical health problems do you have? _______________________________________________

Physician: _______________________________________ Phone: __________________________________

Current Medications: _______________________________________________________________________

Have you ever been hospitalized for a mental or emotional condition? _______________________________

If so, please list where and when:_____________________________________________________________

Do you currently use any alcohol or drugs? __________ If yes, what is your substance of choice?

___________________________________________________________________________________________

Are you in treatment or utilizing support groups (such as AA)? _____ If yes, please describe: _____________

___________________________________________________________________________________________

What types of self-care practices have been helpful to you in the past when dealing with difficult situations? Examples: journaling, exercising, workbooks, prayer, support groups etc.

___________________________________________________________________________________________

**Athletes:**

What competitive sports do you currently play? ___________________________________________

What sport have you played previously? ________________________________________________

Teams Currently On: Middle School High School Travel Team Age you began playing: __________

Is your goal: Collegiate level Professional level Coaching

Additional information you would like us to know about your sport: ______________________________

________________________________________________________________________________

**Artists:**

What is your primary instrument(s) including vocals? _______________________________________

Age you began singing/playing: ________

Are you signed to a recording/publishing/management deal? Yes No

Signed with: ______________________________________________________________________

Additional information you would like us to know about your performance: _________________________

________________________________________________________________________________

**Reasons For Seeking Counseling/Mental Coaching:**

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**In a few words, what do you think counseling/mental coaching is all about?** ____________________

________________________________________________________________________________

**What personal qualities do you think the ideal therapist should possess?** ______________________

________________________________________________________________________________

**Emergency Contact Information for (Client):** ______________________________________________

**Name:** ______________________________________________________________________________

**Relationship:** _________________________________ **Phone:** ________________________________

**Client Signature:** _____________________________________________ **Date:** _________________

**Staff Signature:** ______________________________________________ **Date:** _________________