

HOPE In Home Counseling
PERSONAL INTAKE FORM- MINOR

Today's Date: _____

Name of Child: _____

Age: _____ Date of Birth _____ Place of Birth _____

School: _____ Grade _____

Parents Names _____

Address _____ Phone _____

Please list any physical illnesses, diseases, serious accidents or operations, including inpatient psychiatric care child has had: _____

Who does child live with? _____

How many siblings and ages _____

Has child had counseling before? Yes _____ No _____ When? _____

Where? _____

How is Your child's present physical condition? Good _____ Fair _____ Poor _____

Is child presently taking any prescription medications? Yes _____ No _____

Is child using non-prescription medications? Yes _____ No _____

Please list medications and dosages child is taking currently:

Has child talked about suicide? Yes _____ No _____ How Often _____ Last Time _____

Has child talked about homicide? Yes _____ No _____ How Often _____ Last Time _____

Check any of the following symptoms that have been noticed: Bedwetting_____

Bite Nails_____ Nightmares_____ School Problems_____ Eating Problems_____

Lying_____ Aggressive Behavior_____ Anger/Rage_____ Depression_____

Cutting self_____ Runs Away_____ Crying_____ Sleep Problems_____

Have there been any significant losses/Stressors Yes_____ No._____

Child's personal strengths:

Child's interests/leisure/extracurricular activities:

Briefly explain the current problems or issues you have concerning you child

Parent Signature_____

Date_____

Witness_____

Date_____
