MINOR
Up to 13 years of age
Intake Questionnaire

Please fill out this form to help your therapist know more about you so your counseling sessions can focus on what's most important to you.

Minor **Today's Date**_____

Name of Client_____Age_____DOB_____/_____/_____
Place of Birth: _____Gender: F / M
Address_____City & Zip_____
Phone if applicable: _____
OK to Leave **Voice and Text** messages at this phone? Yes/No
School Currently Attending_____Grade_____
Teacher (if elementary)_____IEP?_____ 504 Plan?_____
Parental Custody / visitation_____
Primary Physician_____Phone_____
Date of and reason for last visit to PCP_____
Other provider(s) involved_____Phone_____
By whom were you referred?_____

Parent / Legal Guardian

Name_____Age_____DOB_____/_____/_____
Relationship to child: ___Biological ____Adoptive ____Step ____Foster
Contacts: Cell_____ (OK to leave message? yes/no)
Home_____ (OK to leave message? yes/no)
Address (if different) _____City & Zip_____
Occupation_____ Employer_____
Schooling completed_____Religion / church_____
Current relationship status: ___Single ___Engaged ___Separated ___Married ___Divorced ___Widowed
___Serious relationship ___Live-in partner ___Remarried

Parent / Legal Guardian

Name_____Age_____DOB_____/_____/_____
Relationship to child: ___Biological ____Adoptive ____Step ____Foster
Contacts: Cell_____ (OK to leave message? yes/no)
Home_____ (OK to leave message? yes/no)
Address (if different) _____City & Zip_____
Occupation_____ Employer_____
Schooling completed_____Religion / church_____
Current relationship status: ___Single ___Engaged ___Separated ___Married ___Divorced ___Widowed
___Serious relationship ___Live-in partner ___Remarried

Stepparent / Parent's Partner (if applicable)

Name_____Age_____DOB_____/_____/_____
Relationship to child_____
Contact phone_____(OK to leave message? yes/no)
Occupation_____Employer_____

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Stepparent / Parent's Partner (if applicable)
Name_____Age_____DOB_____/_____/_____
Relationship to child_____
Contact phone_____(OK to leave message? yes/no)
Occupation_____Employer_____

Family
Names of all persons living in same home(s) with child

Name	Age	Gender	Home (if different)	Relationship

Reasons for seeking counseling for child at this time_____
_____
_____

What have you tried to do up to now to resolve these issues with your child?_____
_____

What do you hope to accomplish in counseling for your child?_____
_____
_____

Has your child seen a counselor before today? ___Yes ___No Dates_____
How did it help?_____
_____

Has your child been given a diagnosis by another professional? ___Yes ___No Dates_____
If Yes, what was the diagnosis(es)_____
_____

What medications does your child take?_____
_____

Describe any significant medical history:_____
_____

Was your child exposed to alcohol, nicotine, or any other drugs during pregnancy?_____

Were there developmental delays in walking, talking, toilet training, etc.?_____
_____

How is your child's appetite?_____

How is your child's sleep?_____

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Does your child have any sensory sensitivities (e.g. light, loud noises, touch, smell, food textures, touch)?
_____

How would you describe your child's personality / temperament?_____
_____
_____

Does your child display significant mood changes? If so how often?_____
_____

Has your child been exposed to difficult or traumatic life experiences including abuse?_____
_____

Has your child ever contemplated or attempted suicide?_____

Describe any past or current self-injury behavior (e.g. cutting, hair pulling, scratching, etc.)_____
_____

Are there immediate or extended family members with ADHD, anxiety, depression, autism or other mental health issues?_____
_____

How is your child's academic performance?_____
_____

How are your child's friendships and peer relations?_____
_____

What are your child's hobbies, interests, pastimes, talents?_____
_____
_____

Describe your child's relationships to parents_____
_____

Describe your child's relationships to siblings_____
_____

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Please feel free to include any other information you think is important here:

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Wendy Reimann, LMFT, LPC
Journeys of Life Counseling, LLC
Consent for Counseling Services
General Information Agreement for Therapy Services

This form provides you, the client, with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA preemptive analysis. Further information is detailed in HIPAA Notice of Privacy Practices posted online at journeysoflifecounseling.com.

Please print your name on the top line, and sign at the X.

I, (name of client)_____
request professional counseling, talk and/or play therapy services.

Confidentiality: please note that children often respond better when therapeutic privacy is afforded. All communication between client and counselor will be held in confidence unless written consent for release is obtained from a parent, with few exceptions: counselors are compelled by law to inform appropriate other person(s), including legal authorities, if there is evidence that a patient is in danger of creating serious bodily harm to self or someone else, or if there is reasonable suspicion a child has been abused. Records may also be released as a result of a court order. If other members of the family participate in a session, they have rights to confidentiality as a collateral participant.

I agree that I will schedule and verify my appointment times for my child with my therapist, and I and my child will show up on time for appointments.

If for some reason I and my child cannot show up for an appointment as scheduled, 24 hours before the scheduled time I will contact my therapist by phone.

I understand that my therapist **will not** be available for 24 hour crisis intervention or emergencies and I have been informed who to contact if I have an emergency; 911 or local Crisis Line 503-291-9111.

I acknowledge that I have received a Professional Disclosure Statement from my therapist and the HIPAA Notice of Privacy Practices is posted at JourneysOfLifeCounseling.com. I will review the documents and know that I am encouraged to discuss any further questions with my therapist at any point in my treatment.

I have read and understand the above information. I consent to therapy in full agreement with the terms stated above and the understanding that my therapist will clarify goals and objectives at any time.

X_____ _____
Child Guardian or legally authorized signature Date

Fee Agreement: I_____ agree to the fee schedule as outlined by Wendy Reimann of Journeys of Life Counseling, LLC ($120/session) unless otherwise noted here.
Fee Agreement:_____

X_____ _____
Signature of Party Responsible for Fee Date

I, _____ Therapist, have discussed the issues above with the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of Therapist_____ Date_____

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