



Tiffany Thibodeaux, LPC, NCC

Professional Counselor for Adults & Adolescents

Adolescent & Child Intake Form

To Be Completed by the Parent/Guardian

Please fill out this form and bring it to your first appointment

PERSONAL INFORMATION		
Name	Date of Birth	Gender
Address	City/Zip	
School	Grade	
Child's Phone Number		

FAMILY INFORMATION		
Mother's Name	Phone Number ()	
Father's Name	Phone Number ()	
Email	Email Appointment Reminders?	Y N
	Text Appointment Reminders?	Y N
Emergency Contact	Emergency Phone ()	
Who does Child live with?		

How did you hear about Tiffany? _____

REQUIRED INSURANCE INFORMATION

Name of Insurance Carrier _____ Member ID # _____

Policyholder's Name _____ Policy holder's DOB _____

Name of Employer _____ Group Number _____

Please note: You are required to verify your benefits before attending your first appointment. Our office will not know your exact benefits & coverage until we receive an explanation of benefits from your insurance company after the first billing.



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School Information

School Name	Grade
Average Report Card Grades <input type="checkbox"/> Honor Roll <input type="checkbox"/> Average Student <input type="checkbox"/> Failing 1 or more class(es)	
Extra-Curricular Activities/Sports:	

Therapy Information

Describe the reason you are seeking counseling for your child.

How long has this problem been going on?

Have your child experienced any major stressors in the last year? (*ex: death of a loved one, major illness, move of home or school, divorce, trauma, loss of employment, abuse, or major life change?*)

What would you like your child to accomplish in counseling?

List some of your child's strengths and weaknesses.

Conditions that your child has been diagnosed with Depression Anxiety Bipolar
 Gender Dysphoria OCD Schizophrenia ADD/ADHD Learning Disability Other

Medical Information

Primary Care Physician	Phone Number		
List any important medical history, chronic ailments, or other health problems.			
Does your child take medication for physical or psychiatric conditions? If yes please list medication below			
Name of Medication	Dosage	Condition Treated	Prescribing Physician
List any psychiatric medications that she/he has taken in the past.			



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Family Information

Explain your child's living arrangements, custody issues, and important people in their lives.

Sibling(s) names and age(s)

Who are the other important people in your child's life that they depend on for emotional support? (include friends, family members, religious organizations, clubs etc.)

Answer the following

Does your child drink alcohol or use illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have your child ever been arrested or incarcerated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child currently have outstanding legal charges or court dates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is anyone requiring your child to attend counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever been physically, emotionally, or sexually abused?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mental Health History

Has your child ever received a mental health diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis Physician Name Year
Have your child ever attended counseling before today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Therapist name Dates: Outcome: <input type="checkbox"/> Successful <input type="checkbox"/> No Change <input type="checkbox"/> Worse
Does your child currently see a psychiatrist or professional who prescribes medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physician name:
Has your child ever had a psychiatric or psychological evaluation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason Physician Name Year
Has your child ever been hospitalized for a psychiatric condition, drug or alcohol abuse, an eating disorder, self-injurious behaviors, or suicidal ideation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason Name of Facility Date(s)
Do you have any close relatives (parents, siblings, grandparents) who have experienced a mental health condition including depression, anxiety, bi-polar disorder, OCD & Schizophrenia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List relationship and diagnosis
Do any close relatives (parents, siblings, grandparents) have or have had drug or alcohol abuse problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List relationship and substance(s) used



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Parental Concerns Checklist

Please read this list and check all issues that concern you about your child.

<input type="checkbox"/> Abuse/ Neglect	<input type="checkbox"/> Grief/loss	<input type="checkbox"/> Oppositional Behavior
<input type="checkbox"/> Academic Problems	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Harms animals	<input type="checkbox"/> Parent Child Conflict
<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Hates being alone	<input type="checkbox"/> Peer Conflict
<input type="checkbox"/> Alcohol/Drug Use	<input type="checkbox"/> Headaches	<input type="checkbox"/> Phobias
<input type="checkbox"/> Anger Problems	<input type="checkbox"/> Homicidal Thoughts	<input type="checkbox"/> Poor attention/concentration
<input type="checkbox"/> Anxious or Nervousness	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Restlessness/on edge
<input type="checkbox"/> Appetite Problems	<input type="checkbox"/> Hostile	<input type="checkbox"/> Risk Taking Behaviors
<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Runs away
<input type="checkbox"/> Blended Family Issues	<input type="checkbox"/> Immature for age	<input type="checkbox"/> Self-centered
<input type="checkbox"/> Can't Say No	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Self-destructive
<input type="checkbox"/> Behavior at School	<input type="checkbox"/> Isolation from others	<input type="checkbox"/> Self-Injury/cutting
<input type="checkbox"/> Cries Often	<input type="checkbox"/> Hypersensitive	<input type="checkbox"/> Separation Issues
<input type="checkbox"/> Damages Property	<input type="checkbox"/> Lack of Friends/ Loneliness	<input type="checkbox"/> Serious illness/injury
<input type="checkbox"/> Depression	<input type="checkbox"/> Lack of Motivation	<input type="checkbox"/> Sexually Acting Out
<input type="checkbox"/> Difficulty Making Decisions	<input type="checkbox"/> Legal Problems	<input type="checkbox"/> Sexual Orientation Issues
<input type="checkbox"/> Distrustful/Guarded	<input type="checkbox"/> Loss of interest in activities	<input type="checkbox"/> Shyness
<input type="checkbox"/> Domestic Violence in Home	<input type="checkbox"/> Low Self Esteem	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Divorce – problems with	<input type="checkbox"/> Lying or stealing	<input type="checkbox"/> Social Anxiety
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Manipulative	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Experienced Trauma	<input type="checkbox"/> Major life Change	<input type="checkbox"/> Suicide Attempts
<input type="checkbox"/> Fighting	<input type="checkbox"/> Mean to Others	<input type="checkbox"/> Tired all of the time
<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Truancy
<input type="checkbox"/> Fearlessness	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Victim of Bullying
<input type="checkbox"/> Fatigue/low energy	<input type="checkbox"/> OCD behaviors	<input type="checkbox"/> Victim of Rape
<input type="checkbox"/> Flashbacks	<input type="checkbox"/> Negative thoughts/outlook	<input type="checkbox"/> Weight Gain/Loss
<input type="checkbox"/> Gender Issues	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Withdrawn

NOTES: _____

Guardian Signature _____ **Date** _____