LAKEVIEW CHURCH

Minor Counseling Intake Form

Page 1 to be completed by Minor

Name: _____ Date: _____

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: _____

Phone Number: _____ Address:_____

Name of Parent(s)/Guardian(s):_____

Who are you presently living with: _____

School: _____ Job (if none leave blank):_____

Hobbies: _____

Do you believe in God? ☐ Yes ☐ No Religious Preference: _____

Fill in the Blank: God is _____

Problems Checklist

Please rate each issue: 1=Major Problem 2=Sometimes a Problem 3=No Concern

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Getting a clear sense of what I value

_____ Worrying about whether I am normal

_____ Excessive worry or anxiety

_____ Dealing with alcohol or drug use

_____ Never eating or eating too much to control weight

_____ Trying to decide on a career

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

_____ Dealing with sexual feelings and/or problems

_____ Getting along with parents or other family members

_____ Feeling bad about the way I look [my body]

Are you currently experiencing any suicidal thoughts or have in the past? ☐ Yes ☐ No

Have you ever attempted suicide or harmed yourself? ☐ Yes ☐ No If Yes (to either of the last 2 questions, explain when and how):_____

_____

Are you presently experiencing any thoughts of harming another person? ☐ Yes ☐ No

Please describe why you are coming to counseling (i.e. what are you are wanting help with)?:

_____

_____

_____

LAKEVIEW CHURCH

Counseling Intake Form Continued

(Page 2-5 to be filled out by parent/guardian of minor)

General

Date: _____ How did you hear about Lakeview Counseling: _____

Full Name of Minor: _____

Name of Parent/Guardian: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Rev. _____

Relationship to the Minor: _____

Contact Information

Address: _____ City: _____ Zip: _____

(Select preferred method of Contact)

Home Phone _____ ☐

Cell Phone _____ ☐

Work Phone _____ ☐

E-mail address: _____ ☐

In case of emergency, contact:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Relational Information

Current marital status: ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If engaged, married, separated, divorced, or widowed, for how long? _____

If applicable, number of previous marriages for you: _____ For your spouse: _____

If married, spouse's name: _____

If divorced, read the following:

> **Per the LPC Code of Ethics**, prior to the commencement of counseling services to a minor client who is named in a custody agreement or court order, a licensee shall obtain and review a current copy of the custody agreement or court order, as well as any applicable part of the divorce decree. A licensee shall maintain these documents in the client's record.*

Please list your children below (include step, adopted, and foster):

Name	***Sex***	***Age or yr of death***	***Relationship to you:***	***Living with:***

Who else lives with you? _____

Counseling or Mental Health History

Please list any previous counseling, psychiatric treatment, substance abuse treatment, or residential/in-patient care your child has received.

Therapist's Name or Program	***Dates***	***Outcome and Diagnosis***	***Medications Prescribed (if any)***

Medical information:

Primary Physician: _____ Phone:_____

Is child currently receiving medical treatment: ☐ Yes ☐ No. If Yes, Please Specify:

_____

List any conditions, illnesses, surgeries, hospitalizations, trauma, or related treatments the child has had:

_____

_____

List all current medications child is taking, including those seldom used or take only as needed:

Medication: _____ Dosage: _____

☐ Improves ☐ Prevents ☐ Controls ⟶ _____

Medication: _____ Dosage: _____

☐ Improves ☐ Prevents ☐ Controls ⟶ _____

Is the child taking these medication(s) according to Doctor's recommendations: ☐Yes ☐No

If No, Briefly Explain:_____

Personal Habits and Health

Approximately, how many hours of sleep does your child get each night? _____

Describe your child's eating habits. _____

_____

Has your child used drugs other than for medical purposes? ☐Yes ☐No

When: _____ What: _____ Amount/Dosage: _____

Do they drink alcoholic beverages? ☐ Yes ☐ No

How much: _____ How often: _____

Have they ever been arrested? ☐Yes ☐No Outcome? _____

Have they ever had a severe emotional upset? If so, explain: _____

_____

Present Concerns and Goals

Please describe why you are bringing your child to counseling (i.e. what are their issues, symptoms, how long, etc.):

_____

_____

_____

Please circle or check the box of any of the following symptoms or problems that pertain to your child and/or family:

List 1	***List 2***	***List 3***
Stress	Marital Problems	Compulsive behaviors
Anxiety	Relationship Issues	Seeing things other don't
Panic	Physical Abuse	Hearing Voices
Depression	Emotional Abuse	Racing thoughts
Lack of Interest	Verbal Abuse	Eating problems
Fatigue	Sexual Abuse	Drug Use
Loss of Appetite	Gender Identity Issues	Alcohol use
Overeating	Anger	Pregnancy
Poor concentration	Aggressive Behavior	Abortion
Trouble sleeping	Bad dreams	Legal Matters
Feeling Worthless	Flashbacks of memories	Work Stress
Grief	Impulsive behavior	Career Choices
Chronic Pain	Controlling	Indecisiveness
Loneliness	Controlled by others	Parenting problems
Fear	Obsessive Thoughts	Financial problems
Low Self-Esteem	Other	Spiritual problems

Has your child attempted to harm themselves? (Current or in the past) ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

What outcome are you hoping to gain from this counseling experience? _____

_____

_____

_____