

Minor Intake Questionnaire

NOTE: You may skip any question that you consider too personal or if it does not relate to the situation. Please write on the back of any page if an answer does not fit in the boxes.

TODAY'S DATE: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

PHYSICAL ADDRESS: \_\_\_\_\_

PO BOX: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ HOME/MESS#: \_\_\_\_\_

PLEASE LIST FAMILY MEMBERS WHO LIVE WITH MINOR AND THEIR ROLE:  
(Age, Relationship to Client: Biological/Adoptive/Step/Grandparent/ Sibs, Etc.)

_____ Name	_____ Age	_____
_____ Name	_____ Age	_____
_____ Name	_____ Age	_____
_____ Name	_____ Age	_____
_____ Name	_____ Age	_____

Is there a court approved custody/parenting plan? \_\_\_\_\_

If so please describe who has custody and the provisions for visitation and medical decision making if any:

\_\_\_\_\_  
\_\_\_\_\_

Medical Insurance Plan if applicable:

\_\_\_\_\_

Insurance ID # \_\_\_\_\_

Group # \_\_\_\_\_

Who is the primary insured?

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Relationship to minor: \_\_\_\_\_

\_\_\_\_\_

LIST ANY CURRENT MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_

CHILD'S DOCTOR:                      PHONE#                      DATE LAST SEEN

PLEASE DESCRIBE THE HISTORY OF THE ISSUES OF CONCERN PRIOR TO COMING HERE FOR HELP:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAS ANYTHING HELPED OR MADE IT WORSE (PLEASE DESCRIBE)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Has minor been in counseling before? What dates and with whom? Was it helpful?

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PAST EMOTIONAL HEALTH HISTORY: Please circle the words that describe child's emotional status. You may write additional information on the back of any page.

DEPRESSED MOOD	Rarely	Sometimes	Often
IRRITABLE MOOD	Rarely	Sometimes	Often
EXTREME MOOD CHANGES	Rarely	Sometimes	Often: How often? _____ days / weeks /months
APPETITE	Down	Ok	Too much
SLEEP	Little	Ok	Too much
ENERGY	Low	Ok	Too much
CONCENTRATION	Unable	Ok	Too focused
NIGHTMARES	None	Sometimes	Often
AGGRESSIVE FEELINGS	Rarely	Sometimes	Often : Describe _____
COMPULSIVITY	Rarely	Sometimes	Often
IMPULSIVITY	Rarely	Sometimes	Often
ANXIETY	Rarely	Sometimes	Often
EXCESSIVE WORRY	Never	Sometimes	Often
PANIC ATTACKS	None	Sometimes	Often
VOICES/VISUAL/TACTILE/OLFACTORY	None	Sometimes	Often
TRAUMA – DV +/-	None	Past	Recent : Describe _____
PHYSICAL/SEXUAL ABUSE	None	Past	Recent : Describe _____
RECENT DEATH / LOSS	No	Yes	Who? _____ When? _____
SIGNIFICANT LIFE CHANGES	None	Past	Recent : describe _____
LEGAL PROBLEMS	No	Yes:Describe: _____	
PSYCHIATRIC HOSPITALIZATIONS	No	Yes:When? _____ Why? _____	

SUICIDAL THOUGHTS	Never	Sometimes	Often Describe: _____
SUICIDE ATTEMPTS	No	Yes: Describe: _____	
SELF-HARM BEHAVIOR	No	Yes: Describe: _____	

HOSPITALIZATIONS: List all medical and psychiatric hospitalizations and/or serious illnesses & the date they occurred. Use back of this page if necessary.

**Name:** \_\_\_\_\_ **Relationship to minor:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

