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Minor Intake

Date:_____

Name of Child/Minor:_____ DOB_____

Address and phone number that child resides_____
_____Zip code_____

Father's name:_____ Age_____

Address:_____ Zip Code_____

Phone: H_____ Msg? Yes ____No ____ Cell _____Msg? Yes___ No____

Mother's name:_____Age_____

Address:_____Zip Code_____

Phone: H_____ Msg? Yes____ No____ Cell_____ Msg? Yes _____No____

PLEASE INDICATE HOW I CAN CONTACT YOU. YOU HAVE THE RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS AND AT ALTERNATIVE LOCATIONS. IF YOU DO NOT WANT YOUR BILLS OR CONFIDENTIAL INFORMATION SENT TO YOUR HOME ADDRESS, I WILL SEND THEM TO A DIFFERENT LOCATION IF YOU WISH.

ALTERNATIVE ADDRESS FOR CONFIDENTIAL COMMUNICATIONS TO BE SENT
_____ZIP_____
Who do I contact in case of an emergency?
_____
Address:_____Phone_____

Family Members and Others Now in Household

Name	Relationship	Age	Marital Status

Who Referred you?_____

May I contact them **ONLY** for purposes to thank them for the referral? NO YES

Please provide a brief summary to describe the reason you are here today. How long has/have the problem(s) existed and what have you done to try to correct the problem. Please include pertinent family history, including how other people in the family have been affected.

_____
_____
_____
_____
_____
_____
_____

Primary Care Physician:_____
Address:_____
City:_____Zip_____
Office Phone number:_____

Is your child on medication? Yes_____ No_____

Current Medication Dose Frequency Present In past
_____
_____
_____

Prescribing Physician:_____

Education/Grade: _____
Current school minor attends_____
Problems in school: NO YES: _____
Has your minor ever had school problems due to drinking/drug use?_____

Counseling History
Does your child have a Psychiatrist?_____
Prior psychological consultation, counseling, or ADHD testing? No ____ Yes ____
When and with Whom?_____
What issues did your child have at that time?
_____
_____
_____

Has your child ever been hospitalized for Psychiatric Reasons? No Yes
When and Where_____

**Has your child ever considered suicide? If so please explain_____
_____

Developmental/Family history

Is your child adopted? ____yes ____no If yes, at what age? _____
Open adoption? ____yes ____no
Contact with the birth parent(s)? ____yes ____no. Please give relevant adoption details_____

Marital/Parent History--Please give year of marriage
From_____To_____
From_____To_____
How many children in the family?_____
During pregnancy, did mother use: __ Cigarettes__ Alcohol__ Drugs __ Experience Extreme Stress?
Specify frequency, amounts, and duration:
_____
List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____
Medical conditions or history (surgeries, asthma, chronic illness)_____
_____

In the first two years, did your child experience: __Separation from mother __Out of home care __Disruption in bonding __Depression of mother __Abuse __Neglect __Chronic pain __Chronic Illness, __Parental Stress

If yes, please specify:
_____
_____
Reached developmental milestones: __On time __Early __Late
How many times has your child moved homes?
_____
Have children witnessed domestic violence? __Y, __N, Specify:
_____
How is your child disciplined? Please list each method and frequency of use:
_____
_____
Has your child been verbally abused? __Y, __N, __Suspected. Specify:
_____
Has your child been physically abused? __Y, __N, __Suspected. Specify:
_____
Has your child been sexually abused? __Y, __N, __Suspected. Specify:
_____

Has your child experienced a traumatic event? If yes, please describe the nature of the trauma and the outcome. Were there initial or lasting emotional effects? If so, please explain in detail.
_____
_____
_____
Other stressors or traumas (i.e. car accidents, bullying, separation from parents, losses)
_____
_____

Circle the symptoms your child displays and list the number of times per week symptom is displayed:

Anger Anxiety/worries Bed wetting Acts out sexually
Conduct problems Controlling Day defecation Unusual sexual knowledge
Day wetting Defiance Depression Homicidal thoughts or actions Insomnia
Dissociates Hyperactivity Masturbates excessively
Hyper vigilance Hallucinations/Delusional thinking Isolation Lack of empathy
Lack of motivation Lethargy Low impulse control Plays out violent themes
Low self-esteem Lying Nightmares Plays out sexual themes
Obsessive thoughts Rituals Over/Under eating Phobias Peer problems Running Away
Shy Sleeplessness Stealing Tantrums Physical Symptoms, i.e. stomachaches

Please show your minor's history of substance abuse (if applicable) by using the following scale.
1-Daily 2-Weekly 3-Monthly 4-Never use

Alcohol/Drug History: (Frequency)

	Current	Past
Alcohol		
Tobacco		
Caffeine		
Cocaine		
Marijuana		
Stimulants		
Diet Pills		
Narcotics/Pain Killers		
Sleeping Pills		
Other:		

Has your child ever been arrested for DUI or other alcohol/drug-related offenses?
____No ___Yes, if so how many times?_____

Have they tried to quit/cut down?_____No_____Yes

Have they experienced withdrawal symptoms_____No_____Yes

Have other (family, friend, spouse, MD, employee) expressed concern or anger about your child's alcohol/drug use?_____Yes _____No

Has anyone in your family, including yourself, had a history of heavy alcohol/drug use? No Yes
If yes who_____

Legal:
Has your child ever been arrested? Yes No
Has your child ever been convicted of a crime? Yes No
Is your child presently on probation? Yes No
If yes, please explain_____

Social Media/Texting

Estimate how many hours your child spends online/texting:

Facebook _____
You Tube _____
Gaming _____
Browsing _____
Texting _____
Other _____

Is this, or has this been a problem for you or your child? If so, please explain_____

Family History Relationship:

Emotional Problems Yes No
Substance Abuse Yes No
Cardiovascular Disease Yes No
Hypertension Yes No
Kidney Disease Yes No
Respiratory Disease Yes No
Cancer Yes No
Diabetes Yes No

Personal History

Emotional Problems	Yes	No	Substance Abuse	Yes	No
Cardiovascular Disease	Yes	No	Hypertension	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Thyroid Abnormalities	Yes	No	Tuberculosis	Yes	No
Head Injuries	Yes	No	Cancer	Yes	No
Respiratory Disease	Yes	No	Other_____		
Neurological Disorders	Yes	No			

Signature of Parent/Guardian_____ Date_____

Signature of Parent/Guardian_____ Date_____