Today's Date: _____

TrueHearted Counseling
Stephen Eller, LPC

Intake Form for Children and Teenagers

Personal Information

Client (Child)

Name: _____ Birthdate: _____ Age: _____

Preferred Name / Nickname: _____ Gender is ☐ Male ☐ Female ☐ Other: _____

Address (1): _____ City: _____ State: _____ Zip: _____

Does child live exclusively at this address? ☐ Yes ☐ No If not, please list child's alternate address below:

Address (2): _____ City: _____ State: _____ Zip: _____

Parent/Guardian (1)

Name: _____ Birthdate: _____ Age: _____

Relationship to Child: _____ Gender is ☐ Male ☐ Female ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Check here if address is same as above: ☐ (1) ☐ (2)

Education Level: _____ Occupation: _____

Parent/Guardian (2) – if applicable

Name: _____ Birthdate: _____ Age: _____

Relationship to Child: _____ Gender is ☐ Male ☐ Female ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Check here if address is same as above: ☐ (1) ☐ (2)

Education Level: _____ Occupation: _____

Parent Phone (1): _____ ☐ Cell ☐ Work ☐ Home

Parent Phone (2): _____ ☐ Cell ☐ Work ☐ Home

E-mail Address (1): _____

E-mail Address (2): _____

Preference(s) for Messages:
☐ Parent Phone (1)
☐ Parent Phone (2)
☐ E-mail Address (1)
☐ E-mail Address (2)

Your Emergency Contact Information

Full Name: _____ Relationship: _____

Phone Number (1): _____ Phone Number (2): _____

Custodial Information

Parent/Guardian relationship status: ☐ Married ☐ Not Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

If other, please describe: _____

If divorced, is there a managing conservator? _____

Please read the following carefully and choose the appropriate option:

☐ I hereby confirm and verify that the client (i.e., child) **is** subject to a court order regarding custody/conservatorship, possession and access, and/or child support.

OR

☐ I hereby confirm and verify that the client (i.e., child) **is not** subject to a court order not have any documents been filed regarding custody/conservatorship, possession and access, and/or child support.

Signature: _____ Printed Name: _____ Date: _____

In the case that the child *is* subject to the court order, please read the informed consent information further into this packet carefully. Stephen Eller does not serve as an expert witness or provide testimonial services to you for court custody and/or divorce hearings.

If you are *not* the child's biological parent, briefly describe why the child is not in the custody of his or her parents:

_____

_____

Who will be bringing your child to counseling? _____

(Please note that if this is someone other than the legal guardian, a consent form must be filled out prior to them bringing the child.)

_____ The adult responsible must stay within walking distance of the office for the duration of the appointment.
(Please Initial)

Important Relationships

Does your child have a close, supportive relationship with any of the following people? Check *all* who apply.

☐Mother ☐Father ☐Step-Parent(s) ☐Other Legal Guardian(s) ☐Sibling(s) ☐Other relatives ☐Friends ☐Teacher(s)

Has your child had periods of significant problems with any of the above? ☐Yes ☐No

If so, who? _____

Your child's usual living arrangements in the past *two* years (check *all* that apply):

☐With mother and father ☐With mother alone ☐With father alone ☐With step-parents ☐With other relatives

☐With foster care ☐With adoptive parents ☐No stable arrangements ☐Other: _____

Does your child live with someone who has a current drug, alcohol, or sexual addiction? ☐Yes ☐No

How many close friends does your child have now? ☐A Lot ☐Several ☐Just a Few ☐One ☐None

How do your child's friends tend to compare in age? ☐Older ☐Younger ☐About the same age

How do you feel about the friends your child chooses? ☐Love ☐Like ☐Don't Like ☐Hate ☐Mixed

Comments: _____

Important Relationships (continued)

Please list important people in the child's family. Depending on your family, this list may include step-parents, step-siblings, half-siblings, grandparents, girlfriend or boyfriend of a parent, cousins, and so on. *You may also include especially important people who are not family members*:

Relationship	Name	Age	Relationship Quality	Comments (Optional)
Father			☐Good ☐Okay ☐Bad	
Mother			☐Good ☐Okay ☐Bad	
			☐Good ☐Okay ☐Bad	
			☐Good ☐Okay ☐Bad	
			☐Good ☐Okay ☐Bad	
			☐Good ☐Okay ☐Bad	
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			☐Good ☐Okay ☐Bad	
			☐Good ☐Okay ☐Bad	
			☐Good ☐Okay ☐Bad	
			☐Good ☐Okay ☐Bad	

List all people who live **in the home** with this child (include name, age, and gender if not listed above):

_____

_____

_____

Health Information

Pregnancy and Birth

How would you describe your pregnancy with this child? ☐Easy ☐Average ☐Some Complications ☐Difficult

Please check any of the following that applied to this child's pregnancy and birth:

☐Medical problems during pregnancy ☐Premature birth ☐Maternal drug or alcohol use ☐Complications at birth

☐Mother experienced physical or emotional violence ☐Neonatal intensive care ☐Health problems as newborn

☐Major life event (such as moving, major relationship changes, or anything else that was especially stressful)

Comments: _____

_____

Childhood Experiences

The following information is sensitive but important for providing accurate treatment. Please share if comfortable.

☐***Check here if you would prefer to discuss this section in person***

Would you say that your child has ever experienced any of the following? Check *all* that apply.

☐Physical violence (or fear that it might happen) ☐Emotional abuse (e.g., often being sworn at, insulted, or humiliated)

☐Physical neglect (i.e., not given food, shelter, medicine) ☐ Emotional neglect (i.e., constantly not feeling loved or supported)

☐Lived with someone who was depressed or mentally ill for long periods of time ☐Witnessed a parent treated violently

☐A household member went to prison ☐A household member was a problem drinker or used street drugs

☐Sexual molestation or abuse ☐Divorce or separation of parents

Comments: _____

_____

Please list any **medical events** which have happened in this child's life from pregnancy to present day (for example, illnesses or diseases, hospitalizations, significant accidents or injuries, surgeries, loss of consciousness, or seizures):

_____

_____

_____

_____

Does your child take any medications? ☐Yes ☐No

List names and doses of all medications: _____

_____

Who prescribed these? _____

Does your child currently experience (check *all* that apply): ☐Asthma ☐Allergies ☐Seizures

_____ If any of the above are checked, I will bring appropriate medications or treatments to ***every*** counseling session.
(Initial)

Health Information (continued)

Child's primary care doctor: _____ Phone Number: _____

Please check any of the following specialists your child works with:

☐Speech Therapist ☐Occupational Therapist ☐Physical Therapist ☐Counselor ☐Psychologist ☐Psychiatrist

☐Mental Health Hospital ☐Rehab ☐Other/Additional Mental Health Treatment

Comments: _____

Counseling History

Is this your child's first time to see a counselor? ☐Yes ☐No

If not, list previous counselor(s) and reason(s) for treatment: _____

_____

Was this a positive experience? ☐Yes ☐No ☐Mixed

Has your child ever been treated for any psychological or emotional problems? ☐Yes ☐No

If so, where? _____

Has your child ever received a mental health diagnosis? If so, what? _____

Safety Information

Has your child **ever** attempted suicide, talked about suicide, or harmed himself/herself in any way? ☐Yes ☐No

Is your child **currently** expressing thoughts about attempting suicide or harming himself/herself? ☐Yes ☐No

Has your child **ever** expressed thoughts about—or attempted to—harm someone *else*? ☐Yes ☐No

Is your child **currently** expressing thoughts about harming someone *else*? ☐Yes ☐No

Please describe **any** self-harm they have used (e.g., cutting, drug use, anorexia, bulimia, biting, head banging, etc.):

_____

Routine

Sleep	How much sleep does your child get, on average? _____
	Does your child have a set bedtime? If so, when? _____
	Does your child have difficulty going to bed or staying asleep? ☐Yes ☐No
Diet	Rate your child's appetite: ☐Healthy ☐Eats too much ☐Eats too little ☐Throws up food
	How would you describe their consumption of caffeine and sugar? ☐Healthy ☐Too much
	Are you happy with your child's eating habits? ☐Yes ☐No
Activity	How active is your child? ☐Maybe too Active ☐Active ☐Not Active ☐Does Very Little
	What activities are they involved in? _____
	How much screen time (TV, video games, phone) do they get? ☐Some ☐Too Much ☐None
Behaviors	Any concerning behaviors? ☐Drug Use ☐In a Gang ☐Sexually Active ☐Pregnancy ☐Other
	Comments: _____
	_____

Family History

Please check any major events (past or present) which have affected your family **in the past few years**:

☐Physical disability ☐Frequent moving ☐Serious illness ☐Psychiatric disorder ☐Persistent money problems
☐Legal problems ☐Attempted or completed suicide ☐Death of a loved one ☐Physical or sexual abuse
☐Birth of a sibling ☐Change in school district ☐Parental remarriage ☐Trauma (natural disaster, car accident, etc.)
☐Other: _____

Has **anyone** in your child's family **ever** struggled with the following (treated or not)? Check *all* that apply:

☐Depression ☐Bipolar Disorder ☐Learning problems ☐Drug abuse ☐Problem drinking
☐Schizophrenia ☐Physical or sexual abuse ☐Attempted or completed suicide
☐Other: _____

Academic Information

Current School: _____ City: _____ Grade Level: _____
Current Teacher(s): _____
Average grades so far this year? _____ Is this typical for them? ☐Yes ☐Usually higher ☐Usually lower
How does your child get along with teachers? _____
How does your child get along with peers? _____

Has your child experienced any of the following? Check *all* that apply.

☐Repeated a grade ☐Skipped school ☐Been suspended ☐Been expelled ☐Refused to do homework
☐Been bullied ☐Been aggressive at school ☐Received an IEP or 504 plan ☐Received tutoring or other support
☐Other/Comments: _____

Do you have any current concerns related to school which are not listed above? ☐Yes ☐No
Comments: _____

Legal and Human Services Information

Has counseling been court ordered? ☐Yes ☐No
If yes, how many sessions? _____ By which judge? _____

Is there **currently** an open CPS case with your family? ☐Yes ☐No
CPS Worker's name: _____ Phone: _____
Has CPS **previously** been involved with your family? ☐Yes ☐No
If yes, when? _____

Current Concerns

Please check any categories that apply. Marking specifics is optional. Either way, we will discuss these in detail when we meet:

☐ Anxiety	☐ Mood	☐ Anger
Check this if your child: worries a lot, has nightmares, clings to you, says "I can't do it" a lot, is too hard on themselves, has difficulty with transitions, complains about feeling sick when nothing is wrong, panics, obsesses, etc.	Check this if your child: is sad a lot, cries easily, seems too sensitive, has mood changes that are unexpected or intense, spends too much time alone, mopes around, isn't interested in things they used to love, etc.	Check this if your child: is easily frustrated, has tantrums, hits, yells, or destroys things, uses bad language, makes threats, leaves you feeling powerless, gets really mad over little things, etc.

☐ Routine	☐ Focus	☐ School Life
Check this if your child: has trouble going to sleep or staying asleep, makes bedtime a chore, eats too much, doesn't eat enough or doesn't eat well, plays video games all day, spends too much time online, etc.	Check this if your child: can't concentrate, is impulsive or hyper, procrastinates, interrupts, gets easily distracted, has a hard time moving from one task to another, seems to daydream too much, can't stay in their seat, etc.	Check this if your child: fights about going to school, has test anxiety, is failing classes, has poor grades, has trouble learning, has problems with teachers, has problems with classmates, is adjusting to a new school, etc.

☐ Friends or Relationships	☐ Behavior or Poor Choices	☐ Difficult Experiences
Check this if your child: is bullied (in person or online), bullies others, gets into fights, seems too shy, seems too bossy, has a hard time making friends, is overly affectionate, shares too much, lost friends, chooses friends poorly, got caught sexting, etc.	Check this if your child: is rebellious, runs away from home, wets/soils their bed or clothing, uses drugs or alcohol, steals or hoards items, looks at pornography, has inappropriate sexual behaviors, sets fires, is mean to animals, has been arrested or has legal charges, etc.	Check this if your child: has experienced something traumatic (such as a natural disaster or car accident), saw someone die or get seriously injured, lost a loved one or a pet, has upsetting memories or flashbacks, has been abused or neglected, etc.

☐ Place in the Family	☐ Development	☐ Self-Worth or Identity
Check this if your child: has a rocky relationship with a family member, resists discipline, is having a hard time adjusting to changes in the family, won't do their chores, is disrespectful, seems isolated, etc.	Check this if your child: acts too young for their age, has imaginary friends (and you're not okay with that), is overly sensitive to touch, sound, light, or motion, has speech difficulties, has tics, sucks their thumb, etc.	Check this if your child: has low self-esteem, puts themselves down, won't stand up for themselves, has concerns related to sexual identity, has religious or spiritual struggles, seems to have no purpose or goals, etc.

☐ Safety	☐ Specific Diagnosis or Other Concerns
Check this if your child: has suicidal thoughts, has **ever** tried to commit suicide, is being abused (or you suspect this), is being hurt, hurts themselves (by cutting, banging their head, purposefully throwing up their food, engaging in very risky behaviors, etc.), or other concerns.	Check this if your concerns are not covered here *or* ***if your child has a specific diagnosis*** (such as ADHD, Autism, etc.). Comments:

How would you describe your child's strengths?		
Their Good Qualities	Their Talents and Abilities	Their Supporters