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MINOR INTAKE FORM

Please complete on behalf of your child

Name of person completing this form: _____

Your relation to the child: _____

Phone: _____ Email: _____

Name of other parent/legal guardian: _____

Phone: _____ Email: _____

Child's first name: _____ **Last name:** _____

Age: _____ Birth day: _____ Month: _____ Year: _____

Ethnicity: _____ Religion: _____ Sex/gender: _____

Home address: _____

Who does your child live with? _____

ACADEMIC INFORMATION:

Name of child's school: _____ Grade/year: _____

Program: _____ Typical grades: _____

HOW YOU FOUND THIS CLINIC:

Word of mouth I'm a former client Order of Psychologists (OPQ)

Psychology Today Rate MDs CJAD 800

Google, using these words: _____

Other: _____

THE REASONS FOR YOUR CHILD'S VISIT:

How intense is your child's emotional distress?

(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)

Please describe: _____

Overall, how much do the problems affect your child's ability to perform school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 6 7 8 9 10 (Incapacitating)

Please describe: _____

When did these problems start? What was going on in your child's life at that time?

PSYCHIATRIC AND MEDICAL HISTORY

Please list any ***psychiatric or "mental"*** problems your child has been diagnosed with:

Please list any ***medical or "physical"*** problems that your child has been diagnosed with:

Please list any **medications your child currently takes**, and what they are taken for:

Name of **Family doctor**: _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results: _____

Name of **Psychiatrist**: _____ Phone: _____

Last visit was during the month of: _____ Year: _____

Results: _____

MENTAL HEALTH TREATMENT HISTORY

Has your child ever been hospitalized for psychological or psychiatric reasons?

No Yes

If yes, please describe when and where, and for which reasons.

Please tell us about any other mental health professionals your child has consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

CURRENT HABITS

Please describe your child's **current habits** in each of the following areas:

Smoking: _____

Drinking: _____

Drug use: _____

TV use: _____

Internet use: _____

Video game use: _____

Caffeine intake: _____

Exercise: _____

Eating: _____

Sleeping: _____

Fun and relaxation: _____

Chores and responsibilities: _____

RELATIONSHIPS

Please describe your child's relationships with each of the following people, if applicable:

Biological Mother: _____

Biological Father: _____

Step-parents: _____

Legal guardians: _____

Siblings: _____

Extended family: _____

Your children: _____
 Friends: _____
 Romantic partner(s): _____
 Colleagues or classmates: _____
 Total number of close, supportive relationships: _____

STRESSFUL LIFE EVENTS

Please describe any significant or stressful life events that your child has been experiencing:

	No	Yes	If yes, please describe
A recent move or change in school?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abuse or neglect?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bullied or ignored by peers?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Academic difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	_____
\Weight control issues?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual orientation concerns?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Self-injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Death or Illness of a loved one or pet?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Family conflict?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Separation or Divorce?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other?	<input type="checkbox"/>	<input type="checkbox"/>	_____

What are your child's positive qualities and skills? What do you like about your child? What qualities have helped your child to succeed at overcoming difficulties in the past?

Please tell us about your child's interests (sports, hobbies, talents, etc.)

Does your child agree that the problem that she or he is seeking help for is problematic?

What are some goals for your child's therapy? What would you like them to achieve by attending therapy?

What concerns do you have about your child attending therapy or working on these problems?

Is there anything else that you would like to mention?
