Intake Form – Individual, Minor

First Name	Last Name	Today's Date

Birth Date	Age	Gender	Sexual Orientation

Grade	School

Name of Parent(s) or Guardian (there is a space below for extra information if you have two households)

Street Address	City	State	Zip

Name of Parent(s) or Guardian (if you have two households)

Street Address	City	State	Zip

Contact Information (don't forget to give me your contact info as well):

Name/Location (example: Mom Cell, Dad Home)	Phone Number	Okay to leave message?	Email (by providing an email, you agree for me to use it as a way to contact you)
		Y N	
		Y N	
		Y N	
		Y N	
		Y N	
		Y N	

Emergency contact: (name, number, relationship to you)

Referred by (if any):

Who do you live with? Please indicate how much time you spend in each household (if more than one), and please list your siblings and their ages.

_____
_____
_____

Please describe any current or previous experiences with counseling or therapy services.

Name of Counselor/Agency	Reason for seeking counseling	Approximate dates	Helpfulness of counseling *None*	*Somewhat*	*Very*
_____	_____	_____	1	2	3
_____	_____	_____	1	2	3
_____	_____	_____	1	2	3

Are you currently or have you ever struggled with sleep problems, eating problems, periods of depression or anxiety? If so, please describe:

_____
_____
_____
_____

Are you currently or have you ever taken any prescribed psychiatric medication (anti-depressants, etc)? If so, please describe:

_____
_____

Have you ever attempted suicide? If so, please describe when and how:

_____
_____

Have you ever engaged in self-harming behaviors (cutting, punching walls, etc)? If so, please describe how often:

_____
_____

Have you ever been hospitalized for psychiatric care? If so, when and for what reason?

_____
_____

Please place a check mark in the appropriate column to indicate the frequency of your recreational drug use. If you have used anything to get high that isn't listed, please write it in.

Frequency of Use:	**Daily**	**Weekly**	**At parties**	**Just tried**	**Date last used**
Alcohol					
Nicotine					
Marijuana					
Cocaine					
Ecstasy					
Pain pills					
Meth					
LSD/Acid					
Sleeping pills					
Heroin					
Inhalants					
Other_____					
Other_____					

Have you ever attended a drug or alcohol rehabilitation group? If yes, where and when?

_____

_____

Have you ever been hospitalized for drug overdose or addiction? If yes, where and when?

_____

_____

Is there anything else you think I should know before we start therapy?

_____

_____

_____

Signature	Date