Minor Counseling Intake Form

Part 1 is to be completed by parent or guardian. **This confidential information is for use by your counselor.*
A copy of student ID, Permit, or photo identification of child is required.

Date: _____ Social Security #: _____/_____/_____

Name: _____ Birth date: _____ Age: _____ Sex: _____ Race: _____

Is there a prior diagnosis? Yes/ No **If yes** please explain:

_____

_____

_____

Is child on any medications:

_____

Are parents of child divorced? Yes/ No **If yes**, a copy of the divorce decree & custody agreement signed by the judge is required. Date of divorce: _____

Does mother or father of this child have primary physical custody?

_____

Are all custody arrangements resolved at this time? Yes or No **If no**, are you currently in court with this issue? Yes or No

Is this child adopted? Yes/ No **If yes**, a copy of adoption paperwork is required.

Mother of Child:

Name: _____ Birth date: _____ Age: _____ Sex: _____ Race: _____

Education level: _____ Religious Affiliation:

_____

Physical Address:

_____

_____

Mailing Address:

_____

_____

Phone: (Home) _____ (Work) _____ (Cell)

_____

Social Security #:_____/ _____/ _____

Is mother remarried? Yes/ No **If yes**, name of spouse

_____

Occupation: _____ Employer:

_____

Note: if a stepparent is going to be bringing a minor to their appointments, a power of attorney will be needed on file with Alaska Center For Natural Medicine.

Father of Child:

Name: _____ Birth date: _____ Age: _____ Sex: _____ Race: _____

Education level: _____ Religious Affiliation: _____

Physical Address:

_____

_____

Mailing Address:

_____

_____

Phone: (Home) _____ (Work) _____ (Cell) _____

Social Security #:_____/ _____/ _____

Is mother remarried? Yes/ No **If yes**, name of spouse

_____

Occupation: _____ Employer:

_____

Note: if a stepparent is going to be bringing a minor to their appointments, a power of attorney will be needed on file with Alaska Center For Natural Medicine.

Part 2 is to be completed by child with the help of parent or guardian depending on child's age

Name: _____ Nickname: _____

School you attend: _____

Grade: _____

Siblings: Age: Sex: City they live in:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Rate your childhood (10 Great- 1 Poor) Circle One- 10 9 8 7 6 5 4 3 2 1 and why:

_____

_____

_____

Religious affiliation:
_____
_____

Have you been to counseling before, if yes, with who?
_____

Describe in your own words what brings you to counseling:
_____
_____
_____
_____

Name your personal strengths and goals:
_____
_____
_____
_____
_____

Do you have a family or friendship support system?
_____
_____
_____

Please rate your distress level for **ALL** of the following:
*Please circle the number that best indicates the existence or severity of the problem according to the following scale.

0=None 1= Minor 2= Moderate 3= Significant 4= Serious

Anger 0 1 2 3 4

_____

Anxiety, worry, stress 0 1 2 3 4

_____

Addiction to drugs/alcohol (self) 0 1 2 3 4

_____

Addiction to drugs/alcohol (family) 0 1 2 3 4

_____

Addiction to pornography 0 1 2 3 4

_____

Addiction to computer/gaming 0 1 2 3 4

_____

Blended family problems 0 1 2 3 4

_____

Brother/sister problems 0 1 2 3 4

_____

Depressed mood, loss of hope 0 1 2 3 4

Domestic violence 0 1 2 3 4

Emotional Abuse 0 1 2 3 4

Experience bullying in school 0 1 2 3 4

Eating problems/concerns 0 1 2 3 4

0=None 1= Minor 2= Moderate 3= Significant 4= Serious

Fear 0 1 2 3 4

Grief 0 1 2 3 4

Guilt 0 1 2 3 4

Head Trauma/concussion 0 1 2 3 4

Low-self esteem 0 1 2 3 4

Panic attacks 0 1 2 3 4

Parent/child conflict 0 1 2 3 4

Physical health problems 0 1 2 3 4

Religious concerns 0 1 2 3 4

Sexual abuse 0 1 2 3 4

Sexual identity issues 0 1 2 3 4

Sexually active 0 1 2 3 4

Sleep problems 0 1 2 3 4

Social concerns 0 1 2 3 4

Suicidal thoughts 0 1 2 3 4

Suicidal actions 0 1 2 3 4

Withdrawn behavior 0 1 2 3 4

Anything else you would like your counselor to know: