Connective Counseling, LLC

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Child Intake Form

Date: _____

Client Name: _____ Phone 1: _____

Do you give permission to leave a voicemail at the contact number above: YES NO

Email address I am permitted to contact you: _____

Parent's Name(s): _____

Phone 1: _____ Phone 2: _____

Address: _____

Custody Arrangement (if applicable): _____

Sex: M F Date of birth:_____ Number of siblings:_____

Describe your relationship with your parent(s): _____

School you attend:_____ Grade:_____

Primary reason for making appointment:_____

Are you currently or have you previously had thoughts of harming yourself: YES NO

Primary physician:_____ Phone:_____

List any significant health issues, severe allergies and/or diagnoses: _____

_____

List any medications you are currently taking: _____

List current and/or previously prescribed psychiatric medication?: _____

Have you previously received any type of mental health services/therapy: YES NO

If yes, when: _____ With whom: _____

Brief description of treatment: _____

How were you referred to this office:_____

Emergency contact:_____ Phone:_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

_____

3. How many times per week do you generally exercise? What types of exercise do you participate in?

_____

4. Please list any difficulties you experience with your appetite or eating patterns: _____

_____

5. Are you currently experiencing overwhelming sadness, grief or depression? □ No □ Yes

If yes, when and for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? □ No □ Yes

If yes, when did you begin experiencing this and how often? _____

7. Are you currently experiencing any chronic pain? □ No □ Yes

If yes, please describe: _____

8. How often do you drink alcohol? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

9. Do you engage in recreational drug use? □ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes How long? _____

On a scale of 1-10, 10 = happiest, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently?

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Alcohol/Substance Abuse yes / no

Anxiety yes / no

Depression yes / no

Domestic Violence yes / no

Eating Disorders and/or Obesity yes / no

Obsessive Compulsive Behavior yes / no

Schizophrenia yes / no

Suicide Attempts yes / no

ADDITIONAL INFORMATION:

1. Do you enjoy your work and is there anything stressful about your current work?

2. Do you consider yourself to be spiritual or religious? □ No □ Yes If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weaknesses?

5. What would you like to accomplish out of your therapy?