CULTIVATING CHANGE

SPRINGFORTH COUNSELING

Minor Client Intake Form

To be completed by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. It, as all communications with your therapist, will be kept confidential to the full extent of Tennessee State Law.

BACKGROUND INFORMATION:

Child's Name: _____ Date of Birth: _____ Age: _____

Child's Address: _____ Street City State Zip Code

Home Phone: _____

Child lives with: Both biological parents _____ Mother _____ Father _____ Mother & Stepfather _____
Father & Stepmother _____ Other (specify): _____

If parents are divorced, describe custody arrangements:

_____

_____

INFORMATION ABOUT CHILD'S MOTHER:

Mother's Name: _____ Age: _____ Race: _____
Employer: _____ Occupation: _____ Hrs/wk: _____
Employer's Address _____
Can you be contacted at work by phone? Yes _____ No _____ Work Phone: _____ Ext.____
Religious Denomination: _____
Describe any physical problems you have that require medication or physical care:

_____

_____

Are you currently receiving medical treatment? Yes _____ No _____ Physician: _____
Medication(s) currently using:

_____
Previous Counseling/Therapy? Yes _____ No _____ If yes, when? _____
With whom and for how long?

_____

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INFORMATION ABOUT CHILD'S FATHER:

Father's Name: _____ Age: _____ Race: _____
Employer: _____ Occupation: _____Hrs/wk: _____
Employer's Address:

_____
Can you be contacted at work by phone? Yes _____ No _____ Work Phone: _____Ext. _____

INFORMATION ABOUT CHILD'S FATHER (CONTINUED):

Religious Denomination: _____

Describe any physical problems you have that require medication or physical care:

_____

Are you currently receiving medical treatment? Yes _____ No _____ Physician: _____
Medication(s) currently using:

_____
Previous Counseling/Therapy? Yes _____ No _____ If yes, when? _____
With whom and for how long? _____

FAMILY MEMBERS:

List all people now living in the household, then draw a line and list others who have lived there during the child's lifetime:

Name	Relationship to Child	Age	Highest School Grade Completed	Occupation

_____
_____
_____
_____
_____
_____
_____
_____

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Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below. Please rate every item. (You may add written comments after areas checked.

0 1 2 3 4 5 6 7 8 9 10

No Concern Moderate Concern Extreme Concern

_____ Depression
_____ Divorce/Separation of Parents
_____ Adjustment to Parent's Remarriage
_____ School Performance
_____ Family Problems
_____ Fearfulness
_____ Physical Problems
_____ Problems with Social Relationships
_____ Problems Sleeping
_____ Sexual Concerns
_____ Religious/Spiritual Concerns
_____ Nightmares
_____ Unhappy Most of the Time
_____ Use of Alcohol
_____ Use of Other Drugs
_____ Work
_____ Worry
_____ Self-esteem
_____ Poor Appetite
_____ Overeating
_____ Bedwetting
_____ Soiling
_____ Cruelty to Animals
_____ Anger/Temper
_____ Talks of Suicide
_____ Other (specify):

Have there been any previous psychological, psychiatric, neurological, or E.E.G. evaluations?
Yes _____ No _____
If yes, please list names, addresses, and dates of contact:

Has child had previous counseling? Yes _____ No _____ If yes, list names(s) of counselor(s), addresses, and dates of
contact(s):_____

Reason for contact:

MEDICAL HISTORY:

Where her any complications surrounding the child's birth? Yes _____ No _____ If yes, describe:

List child's sicknesses, operation, and injuries. Indicate age when occurred, and describe how severe. Pleas pay special attention to head injuries and any time when your child was unconscious, had convulsions, a high fever, or was delirious:

List current medical problems:

Is child currently taking any prescription drugs? Yes _____ No _____ If yes, please list:

When did your child last have a physical examination? _____
Name of Physician: _____Address: _____
How is the child's vision? _____ Hearing? _____

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ACADEMIC/SCHOOL INFORMATION:

Name of school: _____ Grade: _____ Teacher: _____
List previous schools attended with dates:

_____

_____
Has child ever repeated a grade? _____ If so, which one(s)?_____
How does your child get along at school? _____
Describe difficulties in learning at school: _____

_____
Have other family members have learning difficulties? _____

_____

Describe what your child likes to do for fun, special interests, hobbies, etc. _____

_____

_____
Describe your child's religious background (religious denomination is he/she a member of a church, attendance at Sunday School and worship services, religious training at home, prayer life, concept of God, etc.): _____

_____

_____
Anything else you think would be important for the counselor to know: _____

_____

_____

I have read the Spring Forth Counseling Information Sheet and voluntarily request counseling services for my minor child at Spring Forth Counseling in accord with terms described on the information sheet.

Custodial Parent/Guardian(print): _____Date: _____

Custodial Parent/Guardian: _____Date: _____

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PLEASE COMPLETE THE FOLLOWING: (To be completed by child/adolescent)

1. I would like
2. If I were older
3. My friends think
4. What makes me mad is
5. My father/My mother
6. I miss
7. I am scared
8. I often think of myself as
9. My only trouble
10. I dream of
11. Being younger would
12. I hate
13. If I don't get what I want at home
14. What worries me is
15. When I grow up
16. Nothing bothers me more than
17. Other people think I'm
18. I feel unhappy sometimes because
19. Boys/Girls
20. There are times when
21. Being my age is
22. I don't think I can
23. It's tough when
24. At home
25. Teachers are
26. If I am left behind
27. Sometimes I think about
28. If I were smarter
29. Sometimes I feel like
30. It is more important to
31. I wonder if I should
32. If my parents had only
33. I would be happier if
34. I'm glad I'm
35. I wish I were
36. If I could choose my family
37. If only I were not so

38. It would be funny if