



Get Out Of Your Head Therapy

Psychotherapy & Counseling Service for Children, Adolescents and Adults

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MINOR INTAKE QUESTIONNAIRE FORM

Counseling I am seeking: Individual Family Group/Workshop

Office Location: Austin Waco

MINOR'S INFORMATION	PERSON COMPLETING FORM
Name: _____ Date of Birth: ____/____/____ Address: _____ _____ City: _____ Zip: _____	Name: _____ Relationship to Child: _____
PARENT #1 INFORMATION	INDIVIDUALS IN HOUSEHOLD
Name: _____ Date of Birth: ____/____/____ Address: _____ _____ City: _____ Zip: _____ Email: _____ Marital Status: _____ Gender: _____ Please provide a number for confidential voicemails. Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Alternate <input type="checkbox"/> Work Custody status (if applicable): _____ Highest Grade/Degree: _____ Occupation: _____	Sibling: _____ Age: _____ Gender: _____ Sibling: _____ Age: _____ Gender: _____ Sibling: _____ Age: _____ Gender: _____ Sibling: _____ Age: _____ Gender: _____ Other: _____ Age: _____ Gender: _____ Other: _____ Age: _____ Gender: _____
PARENT #2 INFORMATION	SCHOOL INFORMATION
Name: _____ Date of Birth: ____/____/____ Address: _____ _____ City: _____ Zip: _____ Email: _____ Marital Status: _____ Gender: _____ Please provide a number for confidential voicemails. Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Alternate <input type="checkbox"/> Work Custody status (if applicable): _____ Highest Grade/Degree: _____ Occupation: _____	School: _____ Number: _____ Fax: _____ Grade: _____ Teacher: _____ School Counselor: _____ Do you give consent to discuss this child's case with their teacher or school counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child enjoy school? <input type="checkbox"/> Yes <input type="checkbox"/> No



Minor Client Name: _____

STEP PARENT/GUARDIAN (if applicable)	HEALTH CARE PROVIDERS
<p>Does child have any step-parents? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, who remarried? <input type="checkbox"/> Mother <input type="checkbox"/> Father</p> <p>Is there a custody arrangement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name: _____ Date of Birth: ____/____/____ Address: _____ _____ City: _____ Zip: _____ Email: _____ Marital Status: _____ Gender: _____</p> <p>Please provide a number for confidential voicemails. Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Alternate <input type="checkbox"/> Work Custody status (if applicable): _____ Highest Grade/Degree: _____ Occupation: _____</p>	<p>Primary Care: _____ Phone: _____</p> <p>Psychiatrist: _____ Phone: _____</p> <p>Medication List: _____ _____</p> <p>Has child seen a psychiatrist or been in counseling in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Significant medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____</p> <p>Serious accidents or surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain: _____</p>
<p>Name: _____ Date of Birth: ____/____/____ Address: _____ _____ City: _____ Zip: _____ Email: _____ Marital Status: _____ Gender: _____</p> <p>Please provide a number for confidential voicemails. Phone: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Alternate <input type="checkbox"/> Work Custody status (if applicable): _____ Highest Grade/Degree: _____ Occupation: _____</p>	<p>LEGAL/FAMILIAL DETAILS</p> <p>With whom does child reside? _____</p> <p>Who has legal custody of the child? _____</p> <p>Are there any other agencies involved with the family (courts, CPS, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If divorced or separated, is other biological parent aware that child is in counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is child adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, does child know? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>



Minor Client Name: _____

SYMPTOM ASSESSMENT

Please give as accurate of an account as you can. If you have any questions or concerns, please feel welcomed to discuss them with your child's Clinician.

MINOR IS EXPERIENCING...	Never	Seldom	Often	Always	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath, heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					
Frequent nightmares or fear of dark					
Head Aches					
Stomach Aches					
Bedwetting					

MINOR IS FEELING...	Never	Seldom	Often	Always	For how long?
Decreased interest in pleasurable activities					
Social Isolation or feelings of loneliness					
Suicidal thoughts					
Bereavement or feelings of loss					
Changes in sleep (too much or not enough)					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

CARETAKER NOTICES MINOR...	Never	Seldom	Often	Always	For how long?
Is angry, irritable, hostile					
Feels euphoric, energized and highly optimistic					
Has racing thoughts					
Needs less sleep than usual					
Is more talkative than usual					
Has moods that fluctuate (go up and down)					
Finds normal, daily tasks require more effort					
Has decreased interest in pleasurable activities					



Minor Client Name: _____

MINOR HAS...	Never	Seldom	Often	Always	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive thoughts					
Been hearing voices when alone					
Problems with my speech					

MINOR HAS...	Never	Seldom	Often	Always	For how long?
A desire to engage in behaviors I know are risky					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward others					

MINOR IS USING THE FOLLOWING...	Never	Seldom	Often	Always	For how long?
Alcohol					
Nicotine (Vaporizers or tobacco products)					
Marijuana					
Cocaine					
Opiates (Codeine, Methadone, Heroin)					
Sedatives (Quaaludes, Xanax, Valium, Benzos)					
Hallucinogens (PCP, LSD, Shrooms, Ecstasy)					
Stimulants (Adderall, Concerta, Vyvanse)					
Methamphetamines					

MINOR'S EATING INVOLVES...	Never	Seldom	Often	Always	For how long?
Restriction of food consumption					
Bingeing and purging					
Binge eating					
A lot of weight loss or gain					



Minor Client Name: _____

PERSONAL & FAMILY HISTORY

- Has minor ever been hospitalized for a psychiatric illness? YES NO
- Has minor ever thought about suicide, had a plan or attempted suicide? YES NO
- Does minor have a history of sexual abuse? YES NO
- Does minor have a history of physical abuse? YES NO
- Has minor ever been arrested? YES NO
- Has a close relative ever been hospitalized for a psychiatric illness? YES NO
- Does anyone in your family have a mental illness? YES NO
- Has anyone in your family every attempted or committed suicide? YES NO
- Does anyone in your family have a substance abuse problem? YES NO

How well is minor doing in school?

- 0 1 2 3 4 5
- N/A Can't Serious Moderate Mild No
- Function Problems Problems Problems Problems Problems

How well is minor doing in family relationships?

- 0 1 2 3 4 5
- N/A Can't Serious Moderate Mild No
- Function Problems Problems Problems Problems Problems

How well is minor doing in relationships with people outside the family?

- 0 1 2 3 4 5
- N/A Can't Serious Moderate Mild No
- Function Problems Problems Problems Problems Problems

Please rate minor's current physical health?

- 1 2 3 4 5 6
- Very Poor Excellent

Please rate minor's general happiness and well-being?

- 1 2 3 4 5 6
- Very Poor Excellent



Minor Client Name: _____

HISTORY OF PROBLEM

Please describe what concerns you have regarding your child: _____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, or financial problems in the last several years?

What types of activities is your child involved in, or what does your child like to do for fun?

What do you consider to be your child's strengths & limitations?

Strengths: _____

Limitations: _____