Get Out Of Your Head Therapy

Psychotherapy & Counseling Service for Children, Adolescents and Adults

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MINOR INTAKE QUESTIONAIRE FORM

Counseling I am seeking: ☐ Individual ☐ Family ☐ Group/Workshop
Type of Service: ☐ In-Person ☐ Teletherapy

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: _____ ☐Cell ☐Alternate ☐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: _____ ☐Cell ☐Alternate ☐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?** ☐Yes ☐No Does your child enjoy school? ☐Yes ☐No

Minor Client Name: _____

STEP PARENT/GUARDIAN (if applicable)

Does child have any step-parents?
☐Yes ☐No

If so, who remarried?
☐Mother ☐Father

Is there a custody arrangement?
☐Yes ☐No

Name: _____
Date of Birth: ____/____/____
Address: _____
_____
City: _____ Zip: _____
Email: _____
Marital Status: _____Gender: _____

Please provide a number for confidential voicemails.
Phone: _____☐Cell ☐Alternate ☐Work
Custody status (if applicable): _____
Highest Grade/Degree: _____
Occupation: _____

Name: _____
Date of Birth: ____/____/____
Address: _____
_____
City: _____ Zip: _____
Email: _____
Marital Status: _____Gender: _____

Please provide a number for confidential voicemails.
Phone: _____☐Cell ☐Alternate ☐Work
Custody status (if applicable): _____
Highest Grade/Degree: _____
Occupation: _____

HEALTH CARE PROVIDERS

Primary Care:_____
Phone:_____

Psychiatrist:_____
Phone:_____

Medication List:
_____
_____

Has child seen a psychiatrist or been in counseling in the past?
☐Yes ☐No

Significant medical problems?
☐Yes ☐No
Please explain: _____

Serious accidents or surgeries?
☐Yes ☐No
Please explain: _____

LEGAL/FAMILIAL DETAILS

With whom does child reside?
_____
Who has legal custody of the child?
_____

Are there any other agencies involved with the family (courts, CPS, etc.)? ☐Yes ☐No

If divorced or separated, is other biological parent aware that child is in counseling? ☐Yes ☐No

Is child adopted? ☐Yes ☐No
If so, does child know? ☐Yes ☐No

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 Function	Serious Problems	Moderate Problems	Mild Problems	No Problems

How well is minor doing in family relationships?

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

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

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

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: _____