Thrive Counseling Group, LLC

Minor Client Intake Form

Identification:

Person(s) completing this form:_____ Today's date: _____

Child's name: _____ Birthday: _____ Age:_____

Address: _____ Telephone: _____

Mother/female guardian: _____ Age:_____

Address: _____ Preferred Phone: _____

Occupation: _____ Voice message OK?_____

Relationship:[]Biological Mother []Adoptive Mother []Other (please specify)_____

Father/Male Guardian:_____ Age:_____

Address: _____ Preferred Phone: _____

Occupation: _____ Voice message OK?_____

Relationship: [ ]Married [ ]Divorced [ ]Remarried [ ]Never Married [ ]Other

If divorced: [ ]Joint custody [ ]Sole custody–Mother [ ]Sole custody–Father [ ]Custody resolved
[ ]Custody evaluation in progress [ ]Custody being contested [ ]Other (please specify)

Stepparents Name(s):_____

Address: _____ Phone: _____

Occupation(s):_____

Living Arrangement :

[ ] Both parents [ ] One parent [ ] Multiple homes [ ] Guardian/Foster home

Please provide details:

_____

_____

_____

_____

Family History: Please fill out items that apply (who, what, when, circumstances, etc.) Continue on back of page if necessary.

Previous Counseling: _____

Current Counseling: _____

Inpatient Mental Health Treatment:_____

Suicide/Attempted Suicide:_____

Depression/Anxiety: _____

Learning Disabilities: _____

Physical or Sexual Abuse: _____

Drug and/or Alcohol Abuse: _____

Serious Illnesses/Injuries:_____

Legal Difficulties/Other:_____

Please list any major changes your child and/or your family have experienced during the past 5 years: _____

_____

_____

_____

_____

Siblings:

Name	Date of Birth	Description of Relationship (how do they get along?)
1. _____	_____	_____
2_____	_____	_____
3_____	_____	_____
4_____	_____	_____

Pets:

Pet's Name	Type (e.g. cat, dog)	Description of Relationship (how do they get along?)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Other Family or Important People in Child's Life:

Name	Age	Relationship to child	Details
1. _____	__	_____	_____
2. _____	__	_____	_____
3. _____	__	_____	_____

Developmental History:

Problems during pregnancy? [ ] Yes [ ] No Please describe:

_____

_____

_____

Mother's age during pregnancy: _____ Father's age during pregnancy: _____

Did mother [ ] smoke [ ] drink [ ] use drugs [ ] experience illness or [ ]accident during pregnancy? Please explain: _____

_____

_____

_____

Was the child premature? [ ] No [ ] Yes If yes, how premature? _____

Induced? [ ] No [ ] Yes Length of labor?_____ Any other complications or problems?

_____

_____

_____

_____

Early Development:

Problems with: [ ] Feeding [ ] Allergies [ ] Sleeping [ ] Medical [ ] Birth Defects
[ ] Personality [ ] Attachment/Bonding

Delays in: [ ] Saying single words [ ] Crawling [ ] Walking [ ] Talking [ ] Toilet Training
[ ] Fine-motor Coordination

Health: List all childhood illnesses, hospitalizations, medications, allergies, head traumas, significant accidents and/or injuries, convulsions/seizures, and any other event you consider memorable and/or significant:

_____

_____

_____

School:

Current School/grade: _____

Academic concerns: _____

Special education: _____

Behavior concerns:_____

Organized sports:_____

Extracurricular activities: _____

Which subjects/activities in school does this child enjoy the most?

_____

_____

Which subjects/activities in school are most difficult?

_____

_____

Description of child's social interactions at school:

_____

_____

Strengths, Skills, interests, and Talents:

List child's interests, hobbies, skills, talents, recreation, favorite TV shows/video games, toy preferences, friends, etc. Please provide as much detail as possible.

_____

_____

_____

_____

_____

Current Concerns: Circle any of the following that pertain to your child: Troubling Thoughts

Nervousness	Depression/Sadness	Angry/Aggressive	School Problems
Eating Difficulties	Cries Easily	Shyness	Self-Control
Drug/Alcohol Use	Head/Stomach Aches	Loneliness	Feeling Inferior
Fatigue	Difficult to Discipline	Legal Problems	Sleep Difficulties
Fears	Difficulty with friends	Attention/Memory	Nightmares
Separation	Loss of Interest	Suicidal Thoughts	Difficulty Relaxing

Describe all current emotional, behavioral, psychological, problems and concerns:

_____

_____

_____

_____

Treatment:

What would you like to achieve though therapy for this child?

_____

_____

How do you hope therapy might change things for you/your family?

_____

_____

What concerns do you have regarding therapy?

_____

_____

Is there anything else you feel might be important to share?

_____

_____

_____

_____

_____ _____

Parent/guardian signature Date