Healing Hearts
Family Counseling Inc.

**Sheila L. Hansen, LMFT 115782, Registered Play Therapist**
**1601 Dove Street, Suite #100, Newport Beach, CA 92660**
**(949) 424-4083**

# CLIENT INFORMATION / INTAKE FORM – MINOR

Minor's Name: _____ Date: _____
First Middle Last

Age: _____ Date of Birth: _____/_____/_____ Ethnicity: _____

Address: _____

City / State: _____ Zip Code: _____

Phone: _____
Home Cell Work Other

What is the best number to reach you? ☐Home ☐Cell ☐Work ☐Other - May we leave a message? ☐Yes ☐No

Who is the best person to contact regarding minor's therapy sessions? _____
Name of Contact Person

Minor's School: _____ Grade in School: _____

Teacher's Name: _____

Primary reason(s) for seeking services (check all that apply):

| | | | |
|---|---|---|---|
| _____ Alcohol/Drug Use | _____ Anger Problems | _____ Anxiety | _____ Compulsive Behaviors |
| _____ Coping Problems | _____ Defiance | _____ Depression | _____ Eating Problems |
| _____ Fears/Phobias | _____ Hyperactivity | _____ Inattention | _____ Mental Confusion |
| _____ Mood Swings | _____ No Friends | _____ Poor Social Skills | _____ Poor Grades |
| _____ Poor self-concept | _____ Sexual Concerns or Sexual Acting-Out | _____ Sleeping Problems | ____ Suicidal Thoughts/ Threats/Attempt(s) |

Explain/Other: _____

_____

_____

_____

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## FAMILY INFORMATION

Mother: _____ Age / Birthdate: _____/_____
First Middle Last

Address: _____

City: _____ Zip Code: _____

Home Phone: ( ) _____ E-mail: _____

Work #: ( ) _____ Cell #: ( ) _____

Occupation/Place of Employment: _____

_____

*Of all of the methods given above, is there a method you **DO NOT** wish to be used?* _____

Father: _____ Age / Birthdate: _____/_____
First Middle Last

Address: _____

City: _____ Zip Code: _____

Home Phone: ( ) _____ Email: _____

Work #: ( ) _____ Cell #: ( ) _____

Occupation/Place of Employment: _____

_____

*Of all of the methods given above, is there a method you **DO NOT** wish to be used?* _____

Guardian's Name: _____ Age / Birthdate: _____/_____
First Middle Las

Step Mother's Name: _____ Age / Birthdate: _____/_____
First Middle Last

Step Father's Name: _____ Age / Birthdate: _____/_____
First Middle Last

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## FAMILY INFORMATION, cont.

Minor's Parents Are: ☐Married ☐Divorced ☐Separated ☐Never Married ☐Other: _____

If divorced, who has ***legal*** custody?* ☐Mom ☐Dad ☐Joint ☐Other: _____
Please specify

*If seeking psychotherapeutic services for your child and you are divorced, you must show proof of custody status and/or ability to make legal/medical decisions for your child. If there is joint custody, both parents must give written permission for child to receive psychotherapeutic services.

With whom does the minor live at this time? ☐Mom ☐Dad ☐Joint ☐Other: _____
Please specify

Is there any significant information about the parents' current relationship that may be affecting the minor's behavior? _____

Have there been any stressful events (i.e. moves, deaths, injuries, etc.) in the minor's life in the last 18 months?
☐ Yes ☐ No Please explain: _____

Minor is child number _____ in a family of _____ children. Minor child was adopted: ☐ Yes ☐ No

**Please list siblings by age (include step, adopted and half siblings):**

| Name | Age | Sex | Education/Grade | Lives With? | Relationship to Minor Child | Concerns? |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Please list any other person(s) living with minor child:**

| Name | Age | Sex | Relationship | Concerns? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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**Family History - Indicate if any of the following is true for any family members:**

| | Minor | Mother | Father | Sibling | Grandparent | Other – Please specify |
|---|---|---|---|---|---|---|
| Anxiety | | | | | | |
| Depression | | | | | | |
| Suicide | | | | | | |
| Suicide Attempt | | | | | | |
| Alcohol Problem | | | | | | |
| Drug Problem | | | | | | |
| Mental / Emotional Problem | | | | | | |
| Abuse | | | | | | |
| Other Major Trauma (rape, combat, etc.) | | | | | | |

## MEDICAL HISTORY

Name of Physician/Pediatrician:_____ Phone #: ( ) _____

Address:_____
Street City State Zip

Current illness(es) being treated? □ Yes □ No Specify:_____

_____

**Mark any of the following medical conditions the minor has or has had in the past including age of occurrence:**

Heart trouble ____
Diabetes ____
High fevers ____
Kidney trouble ____
Head injury ____
Ear infection(s) ____
Frequent/severe headaches ____

Accident(s) ____
Shortness of breath ____
Bedwetting/soiling ____
Asthma ____
Sleep difficulty ____
Eye problems ____
Seizures/convulsions ____

Fainting / dizziness ____
Stomach problems ____
Neurological disease ____
Other childhood disease(s) ____
Meningitis/Encephalitis ____
Allergies ____

**Please list any other serious illness, injury, or surgery the minor has had:**

| Type of Illness/Injury/Surgery | Name, Address & Phone # of Treating Physician | Date of Illness/Injury/Surgery |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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**Please list all medication(s) minor is currently taking (including non-prescriptions such as vitamins, etc.):**

| Name of Medication | Dosage & How Many Times per Day | Prescribing Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Please list any prior psychotherapy the minor has received:**

| Name of Psychotherapist | Address & Phone # | Date(s) of Service |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please list any hospitalization for psychiatric reasons the minor has had in the past:**

| Name of Hospital | Address & Phone # | Date(s) of Hospitalization |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |

## EMERGENCY CONTACT INFORMATION

**Please provide the names of people we can contact in case of an emergency:**

| Name | Phone # | Relationship to Minor Child |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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## EDUCATION

Current School: _____ School Phone Number: _____
Type of School: _____Public _____Private _____Home Schooled _____Other: _____
Grade: _____ Teacher: _____ School Counselor: _____
In Special Education? _____Yes _____No If yes, describe: _____
In Gifted Program? _____Yes _____No If yes, describe: _____
Has child ever been held back in school? _____Yes _____No If yes, what year(s)? _____
Which subject(s) does the child enjoy in school: _____
Which subject(s) does the child dislike in school: _____
What grades does the minor child usually receive in school? _____
Has there been any recent changes in grades? _____Yes _____No If yes, describe: _____
Has the minor child been tested psychologically? _____Yes _____No By: _____
If yes, describe: _____

**Check the descriptions that specifically relate to your child:**

**Feelings about School / Work:**

___Anxious ___Passive ___Enthusiastic ___Fearful
___Eager ___No expression ___Bored ___Rebellious

**Approach to School Work:**

___Organized ___Industrious ___Responsible ___Interested
___Self-directed ___No initiative ___Refuses ___Does only what is expected
___Sloppy ___Disorganized ___Cooperative ___Doesn't complete assignments
___Other (describe): _____

**Performance in School (Parent's Opinion):**

___Satisfactory ___Underachiever ___Overachiever
___Other (describe) _____

**Minor Child's Peer Relationships:**

___ Spontaneous ___Follower ___ Leader ___Difficulty making friends
___ Makes friends easily ___Shares easily ___ Longtime friends ___Apathetic about friendships
___ Other (describe): _____

**Who handles responsibility for your minor child in the following areas?**

School: ___Mother ___Father ___Shared ___Other _____
Health: ___Mother ___Father ___Shared ___Other _____
Problem Behavior: ___Mother ___Father ___Shared ___Other _____

**If the child is involved in a vocational program or works a job, please fill in the following:**

What is the child's attitude toward work? ___Poor ___Average ___Good ___Excellent

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## BEHAVIORAL / EMOTIONAL

***Please check any of the following that are typical for your minor child:***

_____ Affectionate
_____ Aggressive
_____ Alcohol Use
_____ Angry
_____ Anxiety
_____ Attachment to Dolls
_____ Avoids Adults
_____ Bedwetting
_____ Blinking, Jerking
_____ Bizarre Behavior
_____ Bullies, Threatens
_____ Careless, Reckless
_____ Chest Pains
_____ Clumsy
_____ Confident
_____ Cooperative
_____ Cyber Addiction
_____ Defiant
_____ Depressed
_____ Destructive
_____ Difficulty Speaking or Mute
_____ Dizziness
_____ Drug Use/Dependence
_____ Eating Disorder or Problems
_____ Enthusiastic
_____ Excessive Masturbation
_____ Expects Failure
_____ Fatigue
_____ Fearful
_____ Frequent Injuries
_____Frustrated Easily
_____Gambling
_____Generous
_____Hallucinations
_____Head Banging
_____Heart Problems
_____Hopelessness
_____Hurts Animals
_____Imaginary Friends
_____Impulsive
_____Irritable
_____Lazy
_____Learning Problems
_____Lies Frequently
_____Listens to Reason
_____Loner
_____Low Self-Esteem
_____Messy
_____Moody
_____Nightmares
_____Obedient
_____Cutting
_____Oppositional
_____Over active
_____Over Weight
_____Panic Attacks
_____Phobias
_____Poor Appetite
_____Psychologic Problems
_____Quarrels
_____Sad
_____Selfish
_____Separation Anxiety
_____Sets Fires
_____Sexual Addiction
_____Sexual Acting Out
_____Shares
_____Sick often
_____Short Attention Span
_____Shy, Timid
_____Sleeping Problems
_____Slow Moving
_____Soiling
_____Speech Problems
_____Steals
_____Stomachaches
_____Suicidal Threats
_____Suicidal Attempts
_____Talks Back
_____Teeth Grinding
_____Thumb Sucking
_____Tics or Twitching
_____Unsafe Behaviors
_____Unusual Thinking
_____Victim of Bullying/Teasing
_____Weight Loss
_____Withdrawn
_____Worries Excessively
_____Other: _____
_____

Please describe any of the above (or other) concerns: _____
_____

How are problem behaviors generally handled? _____
_____

What are the family's favorite activities? _____
_____

What does your child/adolescent do with unstructured time?_____
_____

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Please briefly write about the problem(s) or areas of concern that brought you to counseling:

_____

_____

_____

_____

_____

_____

What do you hope to gain from coming to counseling?

_____

_____

_____

_____

_____

Have things improved since you made the initial appointment? ____ YES ____ NO

If so, how have things improved? _____

_____

_____

***Appointment Cancellation Policy:***

***If an appointment is cancelled or missed without 24 hours prior notice, a regular session charge will be made and carried as a balance with payment due at the next appointment. Please note that Monday appointments must be cancelled by noon on Sunday.***

Who referred you to our office? _____

This form was completed by: _____ Date: _____
Name