Healing Hearts
Family Counseling Inc.
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1601 Dove Street, Suite #193, 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

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