Ellie Family Services
Minor Intake Form

Client's legal name: _____ Date: _____
Preferred Name: _____
Gender: _____ F _____ M _____ Other Date of birth: _____ Age: _____
Form completed by (if someone other than client): _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (home): _____ (work): _____ ext: _____
Emergency contact name: _____ Phone: _____

If you need any more space for any of the following questions, please use the back of the sheet.

Primary reason(s) for seeking services:

___ Anger management ___ Anxiety ___ Coping ___ Depression
___ Eating disorder ___ Fear/phobias ___ Mental confusion ___ Sexuality
___ Sleeping problems ___ Addictive behaviors ___ Gender issues ___Hyperactivity
___ Other mental health concerns (specify):

_____
_____

Family History

Parents:

With whom does the child live with at this time?_____

Are parents divorced or separated?_____

If yes, who has legal custody?_____

Were the child's parents ever married? ___Yes ___No

Is there any significant information about the parent's relationship or treatment toward the child which might be beneficial for counseling?___Yes ___No

If yes, describe:_____

Client's Parent:

Name:_____ Age:___ Occupation:_____ ___Full Time ___Part Time
Where employed:_____ Work phone:_____

Parent's education:_____

Is the child currently living with this parent? ___Yes ___No

___Natural parent ___Step-parent ___Adoptive parent ___Foster home

Other (specify)_____

Is there anything notable, unusual or stressful about the child's relationship with this parent?

___Yes ___No If yes, please explain:_____

How is the child disciplined by this parent?_____

For what reasons is the child disciplined by the this parent?_____

Client's Parent:

Name:_____ Age:____ Occupation:_____ ___Full Time ___Part Time
Where employed:_____ Work phone:_____

Parent's education:_____

Is the child currently living with this parent? ___Yes ___No

___Natural parent ___Step-parent ___Adoptive parent ___Foster home

Other (specify)_____

Is there anything notable, unusual or stressful about the child's relationship with this parent?

___Yes ___No If yes, please explain:_____

How is the child disciplined by this parent?_____

For what reasons is the child disciplined by this parent?_____

Additional Parent Information:
_____

_____

Client's Siblings and Others Who Live in the Household:

Names of Siblings	Age	Gender	Live	Quality of relationship with client
_____	___	___F ___M	____home ___away	___poor ___average ___good
_____	___	___F ___M	____home ___away	___poor ___average ___good
_____	___	___F ___M	____home ___away	___poor ___average ___good
_____	___	___F ___M	____home ___away	___poor ___average ___good

Others living in household			Relationship (e.g.-cousin, foster child)
_____	____	___F ___M	_____ ___poor ___average ___good
_____	____	___F ___M	_____ ___poor ___average ___good
_____	____	___F ___M	_____ ___poor ___average ___good
_____	____	___F ___M	_____ ___poor ___average ___good

Comments:_____
_____
_____

Family Health History

Have any of the following illnesses occurred among the child's blood relatives? (parents, siblings, aunts, uncles, or grandparents)

___Allergies	___Deafness	___Muscular Dystrophy
___Anemia	___Diabetes	___Nervousness
___Asthma	___Glandular problems	___Perceptual motor disorder
___Bleeding tendency	___Heart disease	___Mental Retardation
___Cancer	___Kidney disease	___Spinal Bifida
___Cerebral Palsy	___Mental illness	___Suicide
___Cleft palate	___Migraines	___Other (specify)_____

Comments re: Family Health:_____

_____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillbirths? ___Yes ___No

If yes, describe:_____

Was the pregnancy with child planned? ___Yes ___No Length of pregnancy:_____

Mother's age at child's birth:_____ Parent's age at child's birth:_____

Child number ___ of ___total children.

How many pounds did the mother gain during pregnancy? _____

While pregnant did the mother smoke? ___Yes ___No If yes, what amount? _____

Did the mother use drugs or alcohol? ___Yes ___No If yes, type/amount:_____

While pregnant did the mother have any medical or emotional difficulties? (e.g.-surgery, hypertension, medication etc.) ___Yes ___No If yes, describe:_____

Length of labor:_____ Induced? ___Yes ___No Caesarean? ___Yes ___No

Baby's birth weight: _____ Baby's birth length: _____

Describe any physical or emotional complications with the delivery:_____

_____

Describe any complications with the mother or baby after birth:_____

_____

Length of hospitalization: Mother_____ Baby_____

Infancy/Toddlerhood Check all that apply:

___Breast fed ___Milk allergies ___Vomiting ___Diarrhea

___Bottle fed ___Rashes ___Colic ___Constipation

___Not cuddly ___Cried often ___Rarely cried ___Overactive

___Resisted solid food ___Trouble sleeping ___Irritable when awakened ___Lethargic

Developmental History Please note the age at which the following behaviors took place:

Sat alone:_____ Dressed self:_____

Took 1st steps:_____ Tied shoelaces:_____

Spoke words:_____ Rode two-wheeled bike:_____

Weaned:_____ Dry during day:_____

Fed self:_____ Dry during night:_____

Compared with others in the family, child's development was: ___slow ___average ___fast

Age for following developments (fill in where applicable):

Began puberty:_____ Menstruation:_____

Voice change:_____ Convulsions:_____

Breast development:_____ Injuries or hospitalization:_____

Issues that affected child's development (e.g. physical/sexual abuse, inadequate nutrition, neglect, etc.)

_____
_____

Cultural/Ethnic

To which cultural or ethnic group, if any do you belong? _____
Are you experiencing any problems related to cultural or ethnic issues? ___Yes ___No
If yes, describe:_____
Other cultural/ethnic information:_____

Spiritual/Religious

How important to you are spiritual matters? ___Not ___Little ___Moderate ___Much
Are you affiliated with a spiritual or religious group? ____Yes ___No
If yes, describe:_____
Were you raised within a spiritual or religious group? ___Yes ___No
If yes, describe:_____
Would you like your spiritual/religious beliefs incorporated into the counseling? ___Yes ___No
If yes, describe:_____

Education

Current school:_____ School phone number:_____

Type of school: ___Public ___Private ___Home schooled ____Other (specify):_____

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, describe:_____

Which subjects does the child enjoy in school?_____

Which subjects does the child dislike in school?_____

What grades does the child usually receive in school?_____

Have there been any recent changes in the child's grades? ___Yes ___No

If yes, describe:_____

Has your child been tested psychologically? ___Yes ___No

If yes, describe:_____

Check the descriptions which specifically relate to your child.

Feelings about school:

___Anxious ___Passive ___Enthusiastic ___Fearful

___Eager ___No expression ___Bored ___Rebelious

___Other (describe)_____

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)_____

Child's Peer Relationships:

___Spontaneous ___Follower ___Leader ___Difficulty making friends

___Makes friends easily ___Long-time friends ___Shares easily

___Other (describe)_____

Who handles responsibility for your child in the following areas?

School: ___Mother ___Father ___Shared ___Other(specify):_____

Health: ___Mother ___Father ___Shared ___Other(specify):_____

Problem behavior: ___Mother ___Father ___Shared ___Other(specify):_____

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

Current employer:_____ Position:_____ Hours per wk:_____

How have the child's grades in school been affected since working? ___Lower ___Same ___Higher

How many previous jobs or placements has the child had?_____

Usual length of employment:_____ Usual reason for leaving:_____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, school activities, scouts, etc)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical/Physical Health

___Abortion	___Asthma	___Blackouts	___Bronchitis
___Cerebral Palsy	___Chicken Pox	___Congenital problems	___Croup
___Diabetes	___Diphtheria	___Dizziness	___Ear aches
___Eczema	___Encephalitis	___Fevers	___Fevers
___Hayfever	___Heart trouble	___Hepatitis	___Hives
___Influenza	___Lead poisoning	___Measles	___Meningitis
___Miscarriages	___Multiple Sclerosis	___Mumps	___Muscular Dystrophy
___Nose Bleeds	___Other skin rashes	___Paralysis	___Pleurisy
___Pneumonia	___Polio	___Pregnancy	___Rheumatic fever
___Scarlet Fever	___Seizures	___Severe Colds	___Severe head injury
___Sexually transmitted infections		___Thyroid disorders	___Vision problems
___Wearing glasses	___Other (specify)_____		

List of current health concerns:_____

_____

List any recent health or physical changes:_____

_____

Nutrition:

Meal	How often (times per week)	Typical foods eaten	Typical amount eaten
Breakfast	____/week	_____	___No ___Low ___Med ___High
Lunch	____/week	_____	___No ___Low ___Med ___High
Dinner	____/week	_____	___No ___Low ___Med ___High
Snacks	____/week	_____	___No ___Low ___Med ___High

Comments:_____

Most recent examinations:

Type of exam	Date of most recent	Results
Physical exam	_____	_____
Dental exam	_____	_____
Vision exam	_____	_____
Hearing exam	_____	_____

Current prescribed medications	Doses	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current over-the counter meds	Doses	Dates	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Immunization record (check immunizations the child/adolescent has received):

	DPT	Polio		
2 months	____	____	15 months	___MMR (measles, mumps, Rubella)
4 months	____	____	24 months	___HBPV (Hib)
6 months	____	____	Prior to school	___HepB
18 months	____	____		
4-5 years	____	____		

Chemical Use/History

Does the child/adolescent use or have a problem with alcohol or drugs? ___Yes ___No

If yes, describe:_____

Counseling/Prior Treatment History

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counseling/Psych. Treatment	____	_____	_____	_____	_____
Suicidal thoughts/attempts	____	_____	_____	_____	_____
Drug/Alcohol treatment	____	_____	_____	_____	_____
Hospitalization	____	_____	_____	_____	_____

Behavioral/Emotional

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

___Affectionate	___Enthusiastic	___Messy	___Sleeping problems
___Aggressive	___Excessive masturbation	___Moody	___Slow moving
___Aggressive	___Expects failure	___Nightmares	___Soiling
___Alcohol problems	___Fatigue	___Obedient	___Speech problems
___Angry	___Fearful	___Often sick	___Steals
___Anxiety	___Frequent injuries	___Oppositional	___Stomach aches
___Bedwetting	___Frustrated easily	___Over active	___Suicidal threats
___Blinking, jerking	___Gambling	___Overweight	___Suicidal attempts
___Bizarre behavior	___Generous	___Panic attacks	___Talks back
___Bullies, threatens	___Hallucinations	___Phobias	___Teeth grinding
___Careless, reckless	___Head banging	___Poor appetite	___Thumb sucking
___Chest pains	___Heart problems	___Psychiatric problems	___Tics or twitching
___Clumsy	___Hopelessness	___Quarrels	___Unsafe behaviors
___Confident	___Hurts animals	___Sad	___Unusual behaviors
___Cooperative	___Imaginary friends	___Selfish	___Unusual thinking
___Cyber addiction	___Impulsive	___Separation anxiety	___Weight loss
___Defiant	___Irritable	___Sets fires	___Withdrawn
___Depression	___Lazy	___Sexual addictions	___Worries excessively
___Destructive	___Learning problems	___Sexual acting out	___Other:
___Difficulty speaking	___Lies frequently	___Shares	_____
___Dizziness	___Listens to reason	___Sick often	_____
___Drug dependence	___Loner	___Short attention span	_____
___Eating disorder	___Low self-esteem	___Shy, timid	_____

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

_____

How are problem behaviors generally handled? _____

_____

What are the family's favorite activities? _____

_____

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

_____

Has the child/adolescent experienced death? (friends, family, pets, other): ___Yes ___No

At what age?____ If yes, describe the child's/adolescent's reaction: _____

_____

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc)

___Yes ___No If yes, describe: _____

_____

Any additional information that you believe would assist us in understanding your child/adolescent?

_____

_____

_____

Any additional information that would assist us in understanding current concerns or problems?

_____

_____

_____

What are your goals for the child/adolescent's therapy? _____

_____

What family involvement would you like to see in the therapy? _____

_____

Do you believe the child is suicidal at this time? ___Yes ___No

If yes, explain: _____