



Apple Tree

Family Counseling Center, Division

Kathleen Shanahan, MA, MFTI #IMF87529

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Minor Child/Adolescent/Teen Intake (to be completed by Minor)

Date _____

Referred by _____

Minor's Name _____ Gender _____ Date of Birth _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Ethnicity _____ Culture _____

School Name _____ Address _____

School Contact _____ Last Grade Completed _____

I live with (check & fill in all that apply):

- a foster parent or guardian that I call _____
- with another adult (s) who is/are _____
- more than one parent in more than one home _____
- one parent that I call _____
- both parents that I call _____

In your own words, please state the problem that caused you to start therapy. _____

How serious does this problem feel to you? 1 2 3 4 5
 (Circle the number that fits best.) Mildly Upsetting - Extremely Serious

Have you ever wanted to disappear or stop living?



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Have you ever wanted to hurt yourself? If Yes, when and how?

Have you ever wanted to hurt someone else? If so, who, when and how and why?

What would you like to accomplish through therapy? _____

List three of your strengths or things that make you special:

1. _____
2. _____
3. _____

Would you like spirituality/religious issues to be a part of your therapy? Y / N / Don't Know

NOTE: It is important us to determine together what part spiritual/religious issues will or will not take in therapy.

Responsible Party Name _____ **Relationship** _____

Responsible Party Address _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____