Apple Tree
Family Counseling Center, Division
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Minor Child/Adolescent/Teen Intake (to be completed by Responsible Party)

Date_____ Referred by _____

Responsible Party Name_____ Relationship _____

Responsible Party Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email_____

Minor's Name_____ Gender_____ Date of Birth _____

Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Ethnicity_____ Culture _____

School Name_____Address_____

School Contact_____ Last Grade Completed ____

Parent 1)_____ Gender_____ Date of Birth _____

Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Parent 2)_____ Gender_____ Date of Birth _____

Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

Step Parent 1)_____ Gender_____ Date of Birth _____

Address_____

Home Phone_____ Cell Phone_____ _Work Phone_____

Step Parent 2)_____ Gender_____ Date of Birth _____

Address_____

Home Phone_____ Cell Phone_____ Work Phone_____

All Others in Household(s)

Person's Name	Age	Relationship to Minor	Which Household?

In your own words, please state the nature of the main concern. Indicate onset, duration, context, frequency:

_____
_____
_____
_____

How would you rate how serious this concern feels to you? 1 2 3 4 5 (Circle one)
Mildly Upsetting - Extremely Serious

What would you like to accomplish through counseling? _____
_____
_____

Describe child/adolescent/teen's strengths and unique qualities: _____
_____
_____

Would minor like spirituality/religious issues to be a part of your therapy? Y / N / Don't Know
NOTE: It is important for the client and therapist to determine together what part spiritual/religious issues will or will not take in therapy.

MINOR'S DEVELOPMENTAL & FAMILY HISTORY

During pregnancy do any of the following apply to biological/natural mother (if known):
☐ Alcohol ☐ Drugs ☐ Illness ☐ Accident ☐ Problems in Pregnancy ☐ Problems with labor

☐ Problems with delivery ☐ Other:_____

Has minor been adopted? _____If adopted, does minor know? _____

Forms of Discipline Used in the Home: ☐Time Out ☐Loss of Privileges ☐Grounding

☐Rewards/Incentives ☐ Extra chores ☐Physical/corporal punishment

☐Other_____

Do any legal actions impact the child/adolescent? (Please provide dates)

	Current	Past		Current	Past
Custody			Visitation		
Adoption			Child Protective Services		
Probation			Other:		

Please provide copy of Custody Agreement on or before first session.

Custody Arrangement: Physical_____**Legal:** _____

Family stresses: Please provide approximate dates or minor's age at the time.

	Current	Past		Current	Past
Marital problems			Housing problems		
Marital separation			Legal issues		
Divorce			Death of a friend		
Custody disputes			Death of a relative		
Financial problems			Death of a pet		
Job loss			Family illness		
Parents using alcohol/drugs			Other stressors:		

Family Mental Health/Substance Use History:

Please indicate if family members either have in the past or currently suffer from psychological issues such as anxiety, depression, bipolar disorder or schizophrenia or behavioral issues (please identify relationship to child and condition if known) _____

_____

_____

Please indicate if family members suffer from substance use/abuse either currently or in the past (e.g. alcohol, drugs, inhalant, etc.). Again, please identify relationship to the minor and condition, if known:

_____

_____

_____

Is Minor suspected or known to be using alcohol or drugs? If so, please explain. _____

_____

_____

Relationship Development: Check any area of concern.

	Current	Past		Current	Past
Prefers to be alone			Demanding & bossy		
Is alone a lot, but dislikes this and feels lonely			Fights with others		
Is shy			Bullies others		
Has few friends			Teases a lot		
Has many friends			Plays with younger kids		
Plays with "problem kids"			Plays with older kids		

Is picked on a lot			Poor relationships with peers		
Is overly sensitive			Conflict with parents/ step-parents		
Poor relationships with teachers			Has difficulty getting along with siblings		
Sensory concerns			Difficulty with changes in routine		

Academic Attitude & Performance/Discipline: Check all that apply.

	Current	Past		Current	Past
Dislikes school			Missed many school days		
Works hard but does not do well			Repeated a grade		
Unmotivated, refuses to complete work			Discipline referrals, detentions		
Learning Problems			Suspensions (how many?)		
Expulsions (how many?)			Other:		

Academic Supports: Check all that apply.

	Current	Past		Current	Past
Resource classes/special ed.			Continuation school		
Gifted program			Home study		
Speech therapy			Occupational therapy		
Other programs			Independent study		
Intervention Services			Behavior Plan		
Psychological Evaluation			Counseling/Social Work Support		

MINOR'S TREATMENT/THERAPY HISTORY

Has minor ever had any previous counseling or psychotherapy? Y ❑ N ❑ If YES, please list from most recent:

PROBLEM	DATES	THERAPIST & LOCATION	Was Therapy Successful?

Has minor experienced trauma (e.g., witnessed/victim of crime, medical procedure, auto accident, abandonment, etc.)? Y ❑ N ❑ If YES, what happened and when? _____

_____

_____

Has minor ever attempted suicide? Y ❑ N ❑ If YES, when? _____

If YES, method used: _____

Has minor ever been hospitalized for psychiatric reasons? Y ❑ N ❑

DATES	HOSPITAL/LOCATION	LENGTH OF STAY	VOLUNTARY/ INVOLUNTRY

MINOR'S MEDICAL CONDITIONS

Please check all that apply to Minor:

	NEVER	SELDOM	SOMETIMES	OFTEN
Insomnia	❑	❑	❑	❑
Loss of Appetite	❑	❑	❑	❑
Asthma	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Phobias (Fears)	❑	❑	❑	❑
Nausea	❑	❑	❑	❑
Allergies	❑	❑	❑	❑
Nervousness	❑	❑	❑	❑
Loss of temper	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Constipation	❑	❑	❑	❑
Diarrhea	❑	❑	❑	❑
Over-eating	❑	❑	❑	❑
Mood swings	❑	❑	❑	❑
Self-Harm Behaviors	❑	❑	❑	❑
Bedwetting	❑	❑	❑	❑
Night Terrors	❑	❑	❑	❑
Hearing/Seeing Things that are not there	❑	❑	❑	❑
Vision Problems	❑	❑	❑	❑
Hearing Problems	❑	❑	❑	❑
Other: _____	❑	❑	❑	❑

MINOR'S MEDICATION HISTORY

Please check all that apply to Minor:

	NEVER	SELDOM	SOMETIMES	OFTEN
Appetite Suppressants	❑	❑	❑	❑
Pain Relievers	❑	❑	❑	❑
Sedatives/ Tranquilizers	❑	❑	❑	❑
Sleep Aids	❑	❑	❑	❑
Stimulants	❑	❑	❑	❑
Blood Pressure Meds	❑	❑	❑	❑
Heart Medicine	❑	❑	❑	❑
Vitamins	❑	❑	❑	❑
Insulin	❑	❑	❑	❑
Inhaler	❑	❑	❑	❑
Other (please specify): _____	❑	❑	❑	❑

Please list all current medications:

MEDICATION	DOSE	REASON

Comments: