new hope counseling services

Date: _____

Minor Intake Form

The information requested on this form will be kept confidential. Please fill out the form as completely as possible.

Who referred client? _____

What would you like to see happen as a result of counseling?_____

Is the client seeking disability due to his/her current mental/emotional health? ☐ Y ☐ N

Is the client seeking counseling due to a court order or criminal charges? ☐ Y ☐ N

Is there pending/expected court involvement: custody, placement, parental rights, CPS? ☐ Y ☐ N

Client Information

Last Name_____ First Name_____ Middle Initial_____

Gender: ☐ Male ☐ Female

Birth Date_____ /_____ /_____ Social Security Number_____-_____-_____

Street Address_____ Apt #_____

City_____ State_____ Zip_____ Phone_____

Relationship status: ☐ Single ☐ Significant other ☐ Cohabitating ☐ Engaged ☐ Married
☐ Separated ☐ Divorced ☐ Widowed

Racial/Ethnic identity: ☐ African American ☐ Asian American ☐ Hispanic/Latino ☐ Native American
☐ Pacific Islander ☐ White/Caucasian ☐ Other_____

Parent/Guardian's Name_____ Relationship to Client_____

Parent/Guardian's Phone_____ Email_____

Military dependent? ☐ Y ☐ N

Education: Current grade_____ School_____ Problems at school? ☐ Y☐ N

If yes, please explain_____

What services does child receive from school?_____

Is Client Employed: ☐ Y ☐ N

If Yes: ☐ Full-Time ☐ Part-Time ☐ Student

Employer_____

What type of work do you do?_____

Family of Client:

Parents: ☐ Married ☐ Cohabitating ☐ Never Married ☐ Separated ☐ Divorced ☐ Deceased

Mother_____ ☐ Full Custody ☐ Joint Custody ☐ No Rights ☐ Other

Father_____ ☐ Full Custody ☐ Joint Custody ☐ No Rights ☐ Other

If other, please explain: _____

Is there a legal document outlining custody? ☐ Y ☐ N (**copy required prior to client being seen**)

Is the minor in the care of a guardian or conservator? ☐ Y ☐ N If yes, who?_____

What is this person's relationship to the child?_____

Is there a legal document detailing this? ☐ Y ☐ N (**copy required prior to client being seen**)

Siblings: How many?____ I am the: ☐ Oldest ☐ In the Middle ☐ Youngest ☐ Only Child

Sibling Ages_____

How many live in the household?_____

What are the most significant events in clients' life?_____

_____

Has the client or anyone in the client's family experienced abuse or neglect? ☐ Y ☐ N

Is the client currently experiencing abuse or neglect? ☐ Y ☐ N

Is there a history of CPS involvement? ☐ Y ☐ N If yes, please explain_____

Religion/Denominational preference_____ Church (if any)_____

Check all that you have experienced in the last month

☐ Thoughts of suicide	☐ Anxiety	☐ Rage
☐ Thoughts of death	☐ Excessive worry	☐ Anger
☐ Plans to harm self	☐ Panic Attacks	☐ Irritability
☐ Thoughts of harming others	☐ Chronic fear	☐ Relationship to significant other
☐ Plans to harming others	☐ Irrational fears	☐ Relationship to parents
☐ Self-injury	☐ Problems due to abuse/trauma	☐ Relationship to children
☐ Loss of meaning in life	☐ Stress	☐ Sexual problems
☐ Loss of hope	☐ Obsessions	☐ Sexual orientation
☐ Depression	☐ compulsions	☐ Gender identity issues
☐ Decreased pleasure	☐ Phobias	☐ Conflicts at work
☐ Lack of activities	☐ Feel like I'm losing control	☐ Problems in school
☐ Isolating/withdrawn	☐ Restlessness	☐ Loss of faith in God
☐ Decreased energy/fatigue	☐ Muscle tension	☐ Religious doubts
☐ Change in appetite	☐ Problems with sleep	☐ Substance use problems
☐ Significant weight change	☐ Problems with concentration	☐ Hallucinations
☐ Feelings of worthlessness	☐ Problems with memory	☐ Delusions
☐ Grief	☐ Avoid open spaces	☐ Easily distracted
☐ Loneliness	☐ Behavioral problems	☐ Other/Explain below
☐ Guilt feelings	☐ ADHD	

What else is client experiencing at this time?_____

Mental Health History

Has the client experienced mental health problems before? ☐ Y ☐ N If yes, explain_____

_____

Does the client have a family history of mental health problems? ☐ Y ☐ N

Has the client ever received outpatient treatment (counseling, therapy, psychiatrist) for mental health issues?

☐ Y ☐ N If yes, when and where?_____

Has the client ever been hospitalized or received inpatient treatment for mental health issues? ☐ Y ☐ N If yes, when and where?_____

Self-Harm

Has the client ever attempted suicide? ☐ Y ☐ N

Has the client ever lost someone they care about to suicide? ☐ Y ☐ N

If yes, who and when?_____

Substance Use History

Does the client drink alcohol? ☐ Y ☐ N On average, how many drinks do they have?_____ *day/week/month*
quantity & type

per _____

Does the client use drugs (illegal drugs, recreational drugs, drugs not prescribed to the client or used in excess of how they are prescribed)? ☐ Y ☐ N If yes, which ones?_____

How often?_____Per_____ IV drug use? ☐ Y ☐ N
quantity & drug *day/week/month*

Has the client ever been treated (counseling, therapy, psychiatrist, or medication) for a drug or alcohol problem?
☐ Y ☐ N If yes, when and where?_____

Completed successfully? ☐ Y ☐ N

Has the client ever received inpatient treatment (hospital, detox, or rehab) for a drug or alcohol problem?
☐ Y ☐ N If yes, when and where?_____

_____ Completed successfully? ☐ Y ☐ N

Is the client coming in for Alcohol and/or Drug Addiction? ☐ Y ☐ N

Medical History of Client

Pediatrician_____ Date of last medical examination?_____

List any physical illness or symptoms the client is having at this time_____

List major surgeries or illnesses_____

List current medications (include dosages and physician prescribing)_____
_____

ⓘ **Custody or guardianship paperwork is required (if applicable) prior to a minor client being seen for services.**

Acknowledgement

The information written on this form is accurate, to the best of my knowledge.

_____ _____

Signature of Parent/Guardian/Client Date

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Appointment Reminder Preference

Client Name: _____

New Hope Counseling Center utilizes a contracted service to provide automated reminders of your next appointment 24 – 48 hours in advance as a courtesy reminder. Please choose a reminder option.

☐ Yes, I would appreciate a phone reminder. Please call me prior to my appointment at_____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ Yes, I would appreciate a text reminder. Please text me prior to my appointment at_____. I understand that if others have access to this number, confidentiality cannot be ensured.

☐ No, I would prefer not to be reminded of appointments and will keep up with them myself.

_____ _____ _____
Signature of Parent / Guardian / Client | Date | Relationship to client

_____ _____
Signature of New Hope Staff | Date

No Shows and Cancellations

Client Name: _____

When you schedule an appointment with our staff, New Hope Counseling Center reserves that time just for you. If you are not going to attend your scheduled appointment, we would like to give another client the opportunity to take that opening. It affects our funding, our ability to budget our staff, and staff salaries when there are missed appointments. That is why we require **24-hour advance notification of cancellation**. Leaving a message on our voicemail is fine, even on weekends. The time you called will be posted with the message. If you fail to give 24-hour notice before cancelling your appointment or do not show for your appointment up to two times, your therapist has the right to refuse services or you may be asked to make your appointment two to three weeks from missed appointment date. We appreciate the courtesy you extend to us by honoring this agreement. Please note that **we cannot bill your insurance company for missed sessions** or for late cancellations.

Weather Related: Missed appointments due to dangerous weather will not count as a late cancellation.

Due to the counselors maintaining a set schedule:

- If you are 30 minutes late for 60-minute appointment, you will be able to be seen for 30 minutes.

By signing this agreement I acknowledge my understanding of all the policies listed above. I accept and agree to all of the above terms during the course of my treatment at New Hope Counseling Center.

_____ _____ _____

Signature of Parent / Guardian / Client | Date | Relationship to client

_____ _____

Signature of New Hope Staff | Date

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Informed Consent for Psychotherapy/Counseling & Receipt of Privacy Practices

Client Name: _____

I have been provided with a printed copy of the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet. In addition, the therapist/counselor/clinical social worker has provided a verbal explanation of psychotherapy/counseling/clinical social work services and privacy practices, to include exceptions to confidentiality. I have been afforded an opportunity to review the *Explanation of Psychotherapy/Counseling Services and Notice of Privacy Practices* packet, other pertinent information, and to ask questions. All questions have been answered to my satisfaction.

I am making an informed decision, free of any coercion, on behalf of the client to engage in psychotherapeutic/counseling/clinical social work services. It is my right to terminate these services at any point.

_____	_____	_____
Signature of Parent / Guardian / Client	Date	Relationship to client

_____	_____
Signature of New Hope Staff	Date

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?

(Circle your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
FOR OFFICE CODING	*0* + _____	+ _____	+ _____	+ _____

=Total Score_____

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