



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 Cohabiting 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 Cohabiting Never Married Separated Divorced

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 _____

List everyone living in the home with the client (name & relationship) _____

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

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 Isolating/withdrawn 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

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) _____

(i) 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



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 West Texas Counseling & Guidance.

Signature of Parent / Guardian / Client

Date

Relationship to client

Signature of New Hope Staff

Date



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