Peaceful Minds Therapy: Child / Adolescent Intake Form

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Please provide the following information for your child/adolescent (put an x in the boxes which apply to your family and your child/ seeking therapy).The questions below will help your therapist get to know your child/adolescent as well as your concerns for him/her. This information is considered confidential and will not be released without written permission from parent/s or guardian/s

Disclosure for Minors & Parents
Parents under 15 years of age who are **NOT** emancipated have the right by law to examine their child's treatment records unless the therapist feels viewing the records will cause harm to the child. Respecting the child's privacy plays an important role in building a comfortable and trusting relationship between child and therapist. Because the therapeutic relationship is so vital in making progress with this age group, I am requesting parents **NOT** to ask for a copy of their records. However, I will be happy to provide the parent/s with general information about your child's sessions and progress. In addition, I will provide a summary of your child's treatment after therapy has been terminated upon request.

Confidentiality is mandatory broken in cases where child abuse is suspected, in cases of harm to self; such as attempted suicide, and in cases where clear and imminent danger to others is threatened. By **initialing below** you **agree** to the request and information which will be provided to you.

Parent/ Guardian _____

Parent/ Guardian _____

Child/Adolescent Name: _____
First Middle Last

Address: _____
City State Zip

Birth date:_____

Gender: _____

Person completing this form:_____

Relationship to child/adolescent: _____

Mother's Name: _____

Home phone:_____

May we leave a message? ☐Yes ☐No

Cell phone:
May we leave a message? ☐Yes ☐No

May we email you? ☐Yes ☐No

If NO, how can we contact you?_____

Father's Name:_____

Home phone:_____
May we leave a message? ☐Yes ☐No

Cell phone:_____
May we leave a message? ☐Yes ☐No

May we email you? ☐Yes ☐No
If no, how can we contact you?_____

Parents are currently ☐Married ☐Divorced ☐Remarried ☐Never married

Custodial Guardian (if applicable): _____

Stepparent (if applicable): _____

Please list other siblings and their ages:_____

_____

Has anyone in your family (either immediate family or relative) experienced difficulties with the following diagnoses or characteristics? If applicable, put a check mark in the box and please identify the family member (sibling, parent, uncle, etc.).

☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Eating Disorder
☐ Trauma
☐ Bipolar
☐ Panic Attacks
☐ Alcohol/Substance Abuse
☐ Suicide Attempts

Describe any significant medical/developmental history of your child/adolescent including hospitalizations, medications, allergies, etc. Include significant losses.

_____

_____

_____

Name of pediatrician: _____

When was the last time your child/adolescent has seen his/her pediatrician?_____
Does your child/adolescent take any medications? ☐Yes ☐No

If yes, please list all medications and dosages:_____

Meds Dosage:_____

Has your child/adolescent ever been diagnosed with a mental, developmental or intellectual disability/ disorder? ☐Yes ☐No

If yes, at what age? _____

What is the diagnoses/ disorder? _____

Has your child/adolescent ever been seen by a mental health provider (ie. psychiatrist, counselor, social worker, psychologist (therapist)? ☐Yes ☐No

If so, please provide the name of the person:_____
May we contact the person? ☐Yes ☐No

If your child/adolescent was seen in the past what was effect about the treatment?_____

_____

What was **NOT** effective about the treatment? _____

_____

What is the reason for your visit?_____

_____

What is your major concern?_____

Please list any other social or emotional concerns: _____

_____

_____

Where does your child go to school?_____

Does your child/ adolescent have an IEP, 504 or a behavioral plan ☐Yes ☐No
If so, please bring a **copy** to the first visit.

Does your child/adolescent have difficulties socially and /or academically? ☐Yes ☐No
If yes, please explain_____

_____

_____

To your knowledge, does your child/ adolescent do legal /illegal substances? ☐Yes ☐No

If yes, please list them _____

How often does your child/ adolescent do them?_____

At what age did they start? _____

Has your child been involved in the legal system? ☐Yes ☐No

If yes, please explain:_____

Please add any other information you feel is important for the therapist to know about your child/adolescent.

_____

_____

_____

_____

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