



MINOR CLIENT INTAKE INFORMATION

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Parent Name & Phone (Home, Work, and Cell)

\_\_\_\_\_  
In Case of Emergency, Notify (Name and Phone)

Marital Status of Parents:

DAD

\_\_\_\_ Never Married    \_\_\_\_ Married    \_\_\_\_ Widowed    \_\_\_\_ Divorced    \_\_\_\_ Separated

MOM

\_\_\_\_ Never Married    \_\_\_\_ Married    \_\_\_\_ Widowed    \_\_\_\_ Divorced    \_\_\_\_ Separated

If divorced, who has custody? \_\_\_\_\_ Sole \_\_\_\_\_ Joint \_\_\_\_\_

Do both parents have equal rights to seek medical or psychological treatment for your child/children? Yes \_\_\_\_\_ No \_\_\_\_\_

Mom's Lawyer \_\_\_\_\_ Dad's Lawyer \_\_\_\_\_

Presenting problem (State in your own words the reason you want your child to be seen):

\_\_\_\_\_

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Previous counseling, outpatient treatment, substance abuse treatment or hospitalization  
(include dates and therapists)

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Family of Origin (Mother, Father, Brothers, Sisters)

Name	Age	Grade/Occupation	Relationship	Living with Client?
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Medication: \_\_\_\_\_

Child's Primary Care Physician \_\_\_\_\_

Significant Medical History (birth defects, head injuries, allergies, etc.)

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Hobbies/Interests: \_\_\_\_\_

Was the child adopted? \_\_\_\_\_ If yes, at what age? \_\_\_\_\_

History of Significant Losses: \_\_\_\_\_

\_\_\_\_\_

Developmental History:

Any complications during pregnancy? \_\_\_\_\_

\_\_\_\_\_

Was the child premature? \_\_\_\_\_

Did the child seem different in any way from birth or at a very early age?

Explain \_\_\_\_\_

\_\_\_\_\_

Did the child achieve all developmental milestones on time? \_\_\_\_\_ If not,  
explain \_\_\_\_\_

\_\_\_\_\_

Any history of trauma? \_\_\_\_\_

Any history of enuresis / encopresis? \_\_\_\_\_

Any history of destructive behaviors (aggression, running away, cruelty of animals, self harming behaviors, etc.)?

\_\_\_\_\_

\_\_\_\_\_

Any difficulty with child's reaction to starting school? \_\_\_\_\_

\_\_\_\_\_

Does your child have future goals for him / herself? \_\_\_\_\_

\_\_\_\_\_

Does your child have many friends? \_\_\_\_\_

Would you consider your child a leader, follower, or a loner? \_\_\_\_\_

Your expectations for treatment (what do you want to change) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Referral Source \_\_\_\_\_

Other Agencies Involved \_\_\_\_\_

I certify that the above information is correct and give my permission to Counseling Associates of Southern Illinois to use the emergency number listed when unable to reach me at the other number(s) listed.

My parent or guardian may \_\_\_\_\_ may NOT \_\_\_\_\_ be called at their place of employment.

\_\_\_\_\_  
Parent / Guardian Signature Date

\_\_\_\_\_  
Parent / Guardian Signature Date

Parent email (optional) \_\_\_\_\_