crosspoint counseling

YOUTH INTAKE FORM

Name ____ Prefer to be called ______________________________

Gender: Male Female Birth Date ______/______/______ Age _________

School ___________________________________ Grade __________ Home Phone __________________________

Address ____

Reason for coming to counseling/assessment today

____

____

Parent/Guardian Information

Name ____ Occupation ___________________________________

Place of employment ____

Relationship to client: Birth Parent Step Parent Adoptive Parent Legal Guardian

Home phone ______/______/________ May we leave a message? Yes No

Cell phone ______/______/________ May we leave a message? Yes No

Name ____ _____ Occupation ___________________________________

Place of employment ____

Relationship to client: Birth Parent Step Parent Adoptive Parent Legal Guardian

Home phone ______/______/________ May we leave a message? Yes No

Cell phone ______/______/________ May we leave a message? Yes No

Name ____ Occupation __________________________________

Place of employment ____

Relationship to client: Birth Parent Step Parent Adoptive Parent Legal Guardian

Home phone ______/______/________ May we leave a message? Yes No

Cell phone ______/______/________ May we leave a message? Yes No

If biological parents divorced, please answer the following :

Year of divorce _____ Which parent is the primary residential parent? _____

Is there a parenting plan in place? Yes No

Who has non-emergency health care decision making? Mother Father Joint

What is parenting time schedule? _____ Has either parent remarried? Mother: Yes No If yes, year of remarriage _____

Father: Yes No If yes, year of remarriage _____

Please list any siblings this child may have in order of their births.

Name	Age	Relationship	Active part in his/her life
		biological adoptive half step foster	**Y / N**
		biological adoptive half step foster	**Y / N**
		biological adoptive half step foster	**Y / N**
		biological adoptive half step foster	**Y / N**

The following questions refer to your biological family:

Have you, or anyone in your family, ever been diagnosed as having schizophrenia Yes No

Have you, or anyone in your family, ever been diagnosed as being depressed? Yes No

Have you, or anyone in your family, ever been diagnosed as having a drug or alcohol problem? Yes No

Have you, or anyone in your family, ever been diagnosed as being manic/depressive or bipolar? Yes No

Have you, or anyone in your family, ever been diagnosed as having a form of autism? Yes No

Medical/Counseling History

Name of medical doctor _____

For what medical problems is the child being treated currently? _____

_____

_____

Please list all medications currently being taken

Medication	Dosage	Frequency	Prescribed for.....	Date began taking

Has the youth/child received counseling before ? Yes No Seen a psychiatrist before Yes No

Age	Duration	Counselor's Name	Reason for Counseling	Outcome

Within the last five years, have you experienced any off the following?

Change in jobs? Yes No

Significant change in income? Yes No

A move? Yes No

Death of a pet? Yes No

Death of a friend? Yes No

Death of a family member? Yes No

Divorce? Yes No

Marriage? (Yours, a child's, or a parent's) Yes No

Change in living arrangements? Yes No

Birth of a child? Yes No

Adoption of a child? Yes No

Inability to conceive a child? Yes No

Significant spiritual event? Yes No

Loss from a natural disaster? (wind, water, fire) Yes No

Who makes up your primary support system?_____

_____

What do you hope to achieve through this counseling experience? _____

_____

By whom was this child referred for counseling? _____

Spiritual Affiliation

If affiliated with a church/religious group/denomination, please give the name _____

_____

Actively involved? Yes No

Has the minor ever been convicted of a sexual offense against another minor or are child sex abuse charges pending against the minor?

Yes No

_____ _____/_____/_____

(Signature) (Date)