Counsellor Name: ____________________

Child/Teen Client Intake Form

CHILD/TEEN	PARENT/GUARDIAN(S) – Emergency Contact
Name: _________________________________	Name: ___________________________________
Address: _______________________________	Relationship: ______________________________
City: ____________ Postal Code: ___________	Name: ___________________________________
Message OK?	Relationship: ______________________________
Home phone: ________ Y N	*(If different from child/teen)*
Cell phone: __________ Y N	Address: ________________________________
Work phone: __________ Y N	City: ____________ Postal Code: ___________
E-mail (optional):	Message OK?
Preferred means of contact: ________________	Home phone: ___________ Y N
Age/Birth date: ___________	Cell phone: _____________ Y N
Sex: ☐ Male ☐ Female	Work phone: _____________ Y N
	E-mail (optional):
	Preferred means of contact: ____________________

School: _________________________ Grade: _____ Job?____________________________________

Religious affiliation: Christian_____ Other (please specify)______________ None_____

Were you raised by someone other than your biological parents?_____ If yes, please specify: ___________

____

Have you lived in a two-parent home from infancy to the present? _____ If no, please specify: ___________

____

How would you describe the relationship of your parents/guardians with whom you live now, or lived most recently? very unhappy___ unhappy___ neither happy nor unhappy___ happy___ very happy__

Siblings (names and ages): ____

Which of the following best describes your current relationship status?
___I am not dating anyone ___I date but not anyone special
___I have a steady boyfriend/girlfriend ___I am living with someone

Have you ever seen a counsellor, psychologist or been treated by a psychiatrist?_____________________

The reason: ____

What was helpful/ unhelpful about your previous counselling?: ___________________________________

Reason for seeking counselling now?: ____

Name of Doctor: ___________________________ Date of last physical: ___________________________

Current medical problems:____

Current medication and dosage: ____

Any significant hospitalizations or traumas: ____

Have you experienced any concussions recently or in the past? _________ Date: ____________________

Have you had any of these symptoms in the last 6 months?

____ Increase/ decrease in appetite
____ Problems concentrating
____ Difficulty sleeping/insomnia
____ Low motivation
____ Sleeping too much
____ Isolating from others
____ Fatigue/low energy
____ Cycles of highs and lows
____ Cutting/self-harm
____ Frequent anger
____ Depressed mood/sadness
____ Tearful/crying spells
____ Anxiety/fear
____ Hopelessness/ worthlessness
____ Panic
____ Nightmares
____ Trembling or shaking
____ Weight concerns
____ Muscle tension
____ Headaches
____ Dizzy or lightheaded
____ Chest pain
____ Stomach problems
_______________Other (please specify)

Do you have any substance abuse or addictions? (smoking/ alcohol/ drugs/ food/ caffeine/ gambling/ sexual/ other)____

Are you on any special diet, supplements, or have allergies? ____________________________________

Mental Disorders: Anxiety____ Depression____ Schizophrenia____ Other_________________________

Do you have a family history of mental disorders?____

Any suicide attempts?___________ To what degree are you feeling suicidal presently _________
(1 being low & 10 being high)

How supportive is your family or friends? Very supportive____ Somewhat____Not at all____