Child/Adolescent Intake Packet

Some questions may not apply.
Children 12 and older should fill out their own packet as well as the parent/guardian.

Child/Adolescent's Name:_____

Date of Birth:_____ Current Age:_____

Gender Identity:_____ Pronouns:_____ Sexual Orientation:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Is it okay to leave a voicemail? YES NO

E-mail Address:_____

Name of parent/guardian accompanying the minor:_____

Date of Birth:_____ Current Age:_____

Gender Identity:_____ Pronouns:_____ Sexual Orientation:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Is it okay to leave a voicemail? YES NO

E-mail Address:_____

Do you have legal authority to obtain/consent to mental health services for this child? YES NO

Electronic assisted communication (including voicemail, and email) may not always be secure, and that confidentiality cannot be ensured by PIMFT.

Legal Guardian Information for ALL people with custody - *Documentation is required.*

Name:_____

Date of Birth:_____ Current Age:_____

Gender Identity:_____ Pronouns:_____ Sexual Orientation:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Is it okay to leave a voicemail? YES NO

E-mail Address:_____

Type of Custody: ☐ Sole ☐ Primary ☐ Joint ☐ Emergency ☐ Guardianship ☐ Other_____

Name:_____

Date of Birth:_____ Current Age:_____

Gender Identity:_____ Pronouns:_____ Sexual Orientation:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Is it okay to leave a voicemail? YES NO

E-mail Address:_____

Type of Custody: ☐ Sole ☐ Primary ☐ Joint ☐ Emergency ☐ Guardianship ☐ Other_____

Has the child/adolescent been to therapy? YES NO

If so, when/how long? _____

Has the child/adolescent been hospitalized for mental health concerns? YES NO

If so, when/how long? _____

Within the last 30 days, has there been concerns of the child/adolescent having thoughts of hurting themself? YES NO

Within the last 30 days, has there been concerns of the child/adolescent killing themself? YES NO

Has the child/adolescent engaged in self-harm or attempted to end their life? YES NO

Within the last 30 days, has the child/adolescent had thoughts of killing others? YES NO

Please list all medications the child/adolescent is taking:

Medication:_____ Dosage:_____ Prescriber:_____

Date started:_____ Reason:_____

Medication:_____ Dosage:_____ Prescriber:_____

Date started:_____ Reason:_____

Please describe your 2 main concerns:

What is brining you into therapy?_____

When did it begin?_____

What is brining you into therapy?_____

When did it begin?_____

Please list everyone who currently lives in your household:

Name: _____ Gender:_____ Date of Birth:_____ Relationship to You:_____

Name: _____ Gender:_____ Date of Birth:_____ Relationship to You:_____

Name: _____ Gender:_____ Date of Birth:_____ Relationship to You:_____

Name: _____ Gender:_____ Date of Birth:_____ Relationship to You:_____

Please provide the following information about yourself by checking the boxes that apply:

What language do you prefer to speak in therapy?

- ❑ English
- ❑ Spanish
- ❑ Other: _____

What is your racial or ethnic origin?

- ❑ American Indian or Alaska Native
- ❑ Asian or Pacific Islander
- ❑ African-American / Black
- ❑ Caucasian / White
- ❑ Hispanic/Latino/a
- ❑ Other: _____

What is your religious preference?

- ❑ Catholic
- ❑ Protestant
- ❑ Latter-Day Saint
- ❑ Jewish
- ❑ Muslim
- ❑ None
- ❑ Other (specify) _____

Do you have any children? YES NO

❑ How many? _____

What is the highest level of education that you have completed?

❑ Grade school
❑ High school (or GED)
❑ Associate degree
❑ Bachelor's degree
❑ Graduate Student
❑ Master's degree
❑ Doctorate degree

What is your employment status?

❑ Employed full-time
Occupation: _____
❑ Employed part-time
Occupation: _____
❑ Unemployed
❑ Retired
❑ Student

What is your current annual income?

❑ Less than $10,000
❑ $10,000 – $19,999
❑ $20,000 – $29,999
❑ $30,000 – $39,999
❑ $40,000 – $49,999
❑ $50,000 – $59,999
❑ $60,000 – $69,999
❑ $70,000 or above

What is your current relationship status?

❑ Single, never married, not dating
❑ Single, divorced or separated
❑ Single, widowed
❑ Dating
❑ Living together
❑ Engaged to be married
❑ Married
❑ Polyamorous

How long have you been in this current relationship(s)? _____

Problems that are a concern about ***the Child/Adolescent***:

- ❑ chronic illness/pain
- ❑ depression
- ❑ anxiety/worries
- ❑ stress
- ❑ sexual abuse / rape
- ❑ eating disorder
- ❑ relationship problem
- ❑ physical problem
- ❑ excessive alcohol/drugs
- ❑ family relationships
- ❑ sexual problems
- ❑ parenting
- ❑ self-esteem
- ❑ lack of assertiveness
- ❑ suicidal thoughts
- ❑ anger
- ❑ grief
- ❑ self-injury / self-mutilation
- ❑ sexual addiction
- ❑ emotional abuse in childhood
- ❑ physical abuse in childhood
- ❑ sexual abuse in childhood
- ❑ other (please specify): _____

Are there concerns about the child/adolescents weight? YES NO

If yes, please describe: _____

Has the child/adolescent struggled with an eating disorder? YES NO

If yes, how long (length of time)? _____

Are there concerns about the child/adolescent use tobacco/vaping? YES NO

If yes, please describe: _____

Are there concerns about the child/adolescent using alcohol or drugs? YES NO

If yes, please describe:_____

*Problems that are a concern to you about ***YOUR Relationship with the Child/Adolescent:***

- ❑ poor communication.
- ❑ argue about finances.
- ❑ not enough time together.
- ❑ fighting/arguing.
- ❑ physical violence.
- ❑ excessive alcohol/drugs.
- ❑ 12. different values.
- ❑ 13. emotional abuse.
- ❑ 14. difficulties with in-laws/extended family
- ❑ 15. other (please specify): _____

OR

*Problems that are a concern to you about ***YOUR RELATIONSHIP with your Parent/Guardian:***

- ❑ poor communication.
- ❑ argue about finances.
- ❑ not enough time together.
- ❑ fighting/arguing.
- ❑ physical violence.
- ❑ excessive alcohol/drugs.
- ❑ different values.
- ❑ emotional abuse.
- ❑ difficulties with in-laws/extended family
- ❑ other (please specify): _____

Problems that are a concern to you about your ***FAMILY:***

- ❑ Stealing
- ❑ fire setting
- ❑ truancy
- ❑ fighting
- ❑ drugs/alcohol
- ❑ adolescent pregnancy
- ❑ sexual abuse (victim)
- ❑ sexual abuser
- ❑ disobedience
- ❑ divorce adjustment
- ❑ death in family
- ❑ anger
- ❑ peer relationships
- ❑ poor self-esteem

❑ bed-wetting/soiling
❑ destructiveness
❑ issues with stepchildren/stepparenting
❑ eating disorder
❑ self-injury
❑ harm to others
❑ other (please specify) _____

Name: _____

Signature: _____Date: _____

Please bring this with you to your first session.

All children/adolescents must be accompanied by an adult who stays in the building during the duration of the session.

Permission to Treat Minors Form and corresponding custody paperwork must be returned to the clinic before the first session is scheduled.