INSIGHTS COLLABORATIVE THERAPY GROUP
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MINOR INTAKE FORM

Welcome to Insights. We realize that seeking help from a mental health professional for your Child is often a difficult decision. We recognize and applaud your courage and willingness.

This form asks for information about your Child and family so Insights can craft your Child's therapy to be as effective and efficient as possible. Some questions are personal and may be sensitive or even uncomfortable. They are asked in an effort to quickly begin building a complete picture of who your Child is, which in turn will save valuable therapy time. All client records are strictly confidential and will not be seen by anyone without your written permission unless required by law. If you have any questions, please discuss them with your therapist.

Child's Name and Age: _____

Name of person completing this form: _____

Relationship to Child: □Mother □Father □Grandparent □Caregiver □Other (specify): ___

Phone number and email address of person completing this form: _____

Do you give Insights permission to contact you at this phone number and email address: □yes □no

PARENTS' RELATIONSHIP

□married □divorced □unmarried living together
□never married □separated □widowed
□other: _____

Parent 1

Parent 1's Name: _____

Parent 1's Address: _____

Parent 1's Cell Phone: _____

Parent 1's Home Phone: _____

Parent 1's Work Phone: _____

Parent 1's Occupation and Employer: _____

If the Child lives with Parent 1 at this address, please list the names, ages, genders and relationships (sibling, grandparent, etc.) of other persons living with the Child at this address: _____

_____

Parent 1 Contact Permissions:
May we contact Parent 1 at home? □yes □no
May we leave a message at Parent 1's home? □yes □no
May we contact Parent 1 at work? □yes □no
May we leave a message at Parent 1's work? □yes □no
May we contact Parent 1 be cell phone? □yes □no
May we leave a message on Parent 1's cell phone? □yes □no
May we text Parent 1's cell phone? □yes □no

Parent 2

Parent's Name: _____

Parent 2's Address: _____

Parent 2's Cell Phone: _____

Parent 2's Home Phone: _____

Parent 2's Work Phone: _____

Parent 2's Occupation and Employer: _____

If the Child lives with Parent 2 at this address, please list the names, ages, genders and relationships (sibling, grandparent, etc.) of other persons living with the Child at this address: _____

_____

Parent 2 Contact Permissions:
May we contact Parent 2 at home? □yes □no
May we leave a message at Parent 2's home? □yes □no
May we contact Parent 2 at work? □yes □no
May we leave a message at Parent 2's work? □yes □no
May we contact Parent 2 by cell phone? □yes □no
May we leave a message on Parent 2's cell phone? □yes □no
May we text Parent 2's cell phone? □yes □no

Please keep in mind that communications via email over the Internet are not secure. Although unlikely, there is a possibility that information included in an email can be intercepted and read by other parties besides the person to whom it is addressed.

CHILD'S SOCIAL INFORMATION

Child's Teacher: _____

Child's School: _____

Child's School Counselor: _____

Does your Child enjoy school? □yes □no □sometimes

Child's Grade in School: _____

What is the cultural or ethnic identity you claim for your child? _____

What is the religious orientation of your Child (if any)? _____

Who referred you to Insights? _____

May contact that person to say thank you? □yes □no □N/A

WHAT BRINGS YOUR CHILD TO INSIGHTS

Briefly describe what brings your Child to Insights? _____

_____

_____

How concerned are you about the problem(s) that brings you Child to Insights?

□no concern
□little concern
□moderate concern
□serious concern
□very serious concern

What do you hope to accomplish in your Child's therapy? _____

_____

_____

Has your Child ever been seen for counseling or therapy? (This includes licensed professional counselors, psychiatrists, psychologists, social workers, and religious counselors.)

□yes If yes, please include 1) the name of the professional, 2) the dates and duration of services, and 3) the reason for the services _____

_____

_____

□no

Insights is a training facility. Do you consent for a Masters/Ph.D. level intern to sit in on your Child's sessions from time to time? □yes □no

CHILD'S MEDICAL/EMOTIONAL INFORMATION

Child's Primary Physician/s Name: _____

Child's Primary Physician/s Phone: _____

Date of Child's last physical: _____

Child's Psychiatrist's Name: _____

Child's Psychiatrist's Phone: _____

Child's Psychiatrist's Name: _____

What medications (prescribed or over-the-counter) is your Child taking? Please include the name of the medication, purpose, when your Child started taking the medication, and who prescribed the medication. _____

_____

_____

Please list all your Child's medical treatments and operations within the last year _____

_____

_____

Please list all your Child's current illnesses or disabilities _____

_____

_____

Please list all diagnosed or suspected learning disabilities of your Child _____

_____

Please check any of the following that apply to your Child:

□history of violent behavior
□suicide attempts
□suicide plans
□suicidal thoughts
□sexual abuse
□physical abuse
□emotional abuse

Has your Child ever been hospitalized for an emotional disorder, eating disorder, chemical dependency, etc.?

□yes If yes, please describe the dates and reasons for the hospitalization _____

_____

_____

□no

Briefly tell us what you think are your Child's personal strengths and weaknesses (personality, character, intellect, skills, talents, achievements, etc.) _____

_____

_____

Please tell us anything we have forgotten to ask that you think is important for us to know about your Child

_____

_____

Briefly tell us what you think are your Child's personal strengths and weaknesses (personality, character, intellect, skills, talents, achievements, etc.) _____

_____

_____

If the Child's parents are unmarried, divorced, or divorcing, please bring copies of all currently applicable child custody/conservatorship and visitation agreements and court orders as well as any divorce decree.

□yes, copies will be provided at the parent consultation meeting.
□no, no documents apply

By signing below, I acknowledge I am providing this information for use by Insights Collaborative Therapy Group.

_____

Signature Date