Beth Linfoot, Counseling, PLLC

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Personal History Intake Packet for Minors

Client Name: _____
Date: _____
Gender: ▫ M ▫ F Date of birth: _____
Age: _____
Grade in school: _____
Name of school: _____

Forms completed by (if someone other than client):
_____

Address: _____ City: _____
Zip: _____

Phone (home): _____ Work: _____
Cell: _____

Email
Address_____

May I contact you by: (please check all that apply)
▫ Phone call ▫ Leaving a voicemail message ▫Text Message ▫ Email ▫ U.S. Postal Mail
Emails

While every precaution is taken to ensure confidentiality on the internet, emails can be hacked and information can be seen by unwanted parties. Please initial to indicate your understanding of the associated risks with email communication and your acceptance of receiving emails.
_____

Primary reason(s) for seeking services for a minor
▫ Addictive Behaviors ▫ Communication Skills ▫ Personal Growth
▫ Trauma History ▫ Coping ▫ Parenting
▫ Anger management ▫ Depression ▫ Relationship concerns
▫ Anxiety ▫ Behavioral Concerns ▫ Sexual Concerns
▫ Career/Education ▫ Fear/Phobias ▫ Sleeping Problems
▫ Grief & Loss ▫ Giftedness ▫ Special Needs
▫ Separation/ Divorce ▫ Social struggles ▫ Family Conflict
▫ Other: _____

While I am happy to help, please know that a referral to a different counselor/therapist may be in order to best meet your child's needs. I will happy to help you set that up if necessary.
_____Please initial here to indicate your understanding of the limits of my specialties and the ethical obligation to make referrals when there is a mismatch between need and services.

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Please indicate who the services are for: _____.
Relationship to you: ___ Child ___ Step Child ___ Adopted Child ____ Grandchild ____ Foster Child
___ Other:
_____

What are your goals for the child's therapy? Please include child's input as appropriate.
_____

_____

_____

Do your child feel suicidal at this time? ▫ Yes ▫ No, if Yes, explain:
_____

_____

Has the child experienced major changes/events during the past year? ▫ Yes ▫ No, if Yes, explain:
_____
_____

Is the child presently seeing another counselor? ▫ Yes ▫ No, If Yes, Who?
_____

Has the child had previous counseling or psychotherapy? ▫ Yes ▫ No If Yes, please share when and for what reason.
_____

_____

<u>Behaviors/Symptoms Check behaviors/symptoms that occur more often than you would like:</u>
▫ Anger/aggression ▫ Fatigue ▫ Panic Attacks
▫ Alcohol/drug use ▫ Gambling ▫ Phobias/Fears
▫ Anti-social behavior ▫ Hallucinations ▫ Recurring thoughts
▫ Anxiety ▫ Heart Palpitations ▫ Sexual thoughts/acts
▫ Avoidance ▫ High blood pressure ▫ Seeing things/visions

▫ Chest pain ▫ Hopelessness ▫ Sick often
▫ Critical of self/others ▫ Irritability ▫ Sleep problems
▫ Cyber/internet use ▫ Judgment errors ▫ Suicidal thought
▫ Depression ▫ Loneliness ▫ Thoughts disorganized
▫ Disorientation ▫ Memory impairment ▫ Withdrawing
▫ Distractibility ▫ Mood shifts ▫ Worrying
▫ Elevated mood ▫ Over/under eating

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Education
Current grade: _____ Home schooled? ____ YES ___ NO

Does the child visit with the school counselor or participate in social skills groups or other groups?
___YES ___ No

Family Information
*Note: Please include all people living in the home. You may use the back of the page if needed.
Child's Development from Birth

Relationship
Mother: Name _____ Age _____ Living Y___ N ____ Living in home Y ____N ___
Father Name _____ Age _____ Living Y___ N ____ Living in home Y__N ___

Spouse/Partner Age _____ Living Y___ N ____ Living in home Y__N ___

Siblings Ages _____ Living Y___ N ____ Living in home Y__N ___

Delivery Term: ____ Full term ____ Born early at ____weeks gestation. Time in NICU:_____

Age at which child began walking: _____

Age at which child began talking: _____

Has the child receive any early interventions: ____No ____Yes Which ones? __Speech ___OT ___PT
Has the child receive any diagnosis prior to today's appointment?
_____
Please list significant others, siblings, grandparents, half-relatives, etc.
Living? Living with you?

Family of Origin (the family the client was born into and/or raised with)
Child's Parents:
▫ Married/Together
▫ Divorced/Separated
▫ Mother remarried; Number of times: _____
▫ Father remarried; Number of times: _____

Please note the age of the child at time of divorce if applicable: _____
▫ Special circumstance (e.g. raised by person other than parents)
Please describe:_____
__
Development
Are there unusual or traumatic circumstances that affected the child's development? ▫ Yes ▫ No
If Yes, describe:
_____

Is there a history of abuse? ▫ Yes ▫ No
If Yes, which type(s)? ▫ Sexual ▫ Emotional ▫ Physical ▫ Verbal
If Yes, the abuse was as a: ▫ Victim ▫ Perpetrator

Other childhood issues: ▫ Neglect ▫ Inadequate nutrition ▫ Other: _____

Cultural/Ethnic
To which cultural or ethnic group do you belong?
_____

Is your child experiencing problems due to cultural or ethnic issues? ▫ Yes ▫ No
If Yes, please describe:
_____

Other cultural/ethnic information you want to share:
_____
_____

Religious/Spiritual
How important to your child are religion/spirituality? ▫ Not at all ▫ A little ▫ Moderately ▫ Very
Do you and your child belong to a religious or spiritual group? ▫ Yes ▫ No If Yes, Which one do you belong to? _____

Do your religious or spiritual beliefs help you and your child cope in life? ▫ Yes ▫ No If Yes, explain:
_____
_____
Would you like your religious or spiritual beliefs incorporated into counseling? ▫ Yes ▫ No
If yes, describe:
_____
_____

Support Network
My child's network of support and encouragement includes the following: (check all that apply)
▫ Myself ▫ Classmates ▫Extra-curricular group
▫ Neighbors ▫ Family of origin ▫ Extended Family ▫ Friends
▫ Religious/Spiritual Group ▫ Social Networks ▫ Other: _____

Medical/Physical Health
Does the child have (or have a history of) medical problems in the following areas:
▫ Neurological ▫ Abdominal pain or difficulties with elimination
▫ Chronic Pain ▫ Musculoskeletal
▫ Ear/Nose/Throat ▫ Skin
▫ Cardiology ▫ Respiratory
▫ Other:
_____
__
Explanation if necessary:
_____
_____
_____
_____
Medical/Physical Health (continued)
List any recent health or physical changes for the child:
_____
_____
_____
_____
Has the child ever been hospitalized? ▫ Yes ▫ No If so, for what? (Please list only those that occurred in the last 3 years or are related to the child's current issue or problem.)

Substance Use Questions
Does the child drink alcohol? ▫ Yes ▫ No If Yes, how much?
_____
Does the child use illegal drugs? ▫ Yes ▫ No If Yes, what/how much?
_____

Describe when and where the child typically use substances:
_____

Describe how the child's use has affected your family and/or friends.
N/A_____
Explanation:_____
_____
_____
_____
Reasons for use: ▫ Addiction ▫ Socialization
▫ Escape ▫ Taste
▫ Self- medication ▫ Other: _____
****

Please read, initial, sign and date to complete the Client History Intake

Thank you for taking time to complete the Client History Intake Packet for Minors. While it is detailed and lengthy, please know it is necessary to have as much information as possible to get the best picture of your child's current circumstances so that an effective treatment plan can be put in place. As mentioned earlier, if there appears to be a mismatch in your child's needs and our services, we will be happy to assist you in seeking a professional who can support you and your child's therapeutic goals.

_____ Please initial here confirming that the information in this packet is true and accurate to the best of your knowledge and you understand we may or may not begin working together based on the information found herein.

_____

_____ _____

Parent/ Guardian's Signature

Today's Date