STILL WATERS COUNSELING HI LLC
Child/Adolescent In-Take Form

Client Information – Minor Child/Adolescent

Name _____Date _____
First Middle Last

Age _____ Date of Birth _____ Sex: Male Female

Home Address

_____
Street City State Zip

Your cell phone _____ Home phone _____

Mother's cell phone _____ Father's cell phone _____

Which phone number would you prefer me to use to contact you? _____

Is it O.K. to text scheduling information only to that number? _____

e-mail address (optional) _____

Birthplace _____ Place(s) where raised _____

Grade in school _____ Do you also work part-time, and if so, where? _____

Where do you go to school? _____

Have you attended any other schools before this _____

Do you have a religious preference? _____

If adolescent, are you currently dating or in a relationship? _____

If adolescent, have you recently broken up from a relationship? _____

Parents (please list names, ages and occupations; if deceased, please note year of death)

_____

_____

_____

Continued

Client's name _____

Siblings (Please list ages and occupations (if applicable) and if they are half or full siblings. Please also list grade levels or highest level(s) of education achieved by each.

Name	Age	Occupation	Half/Full	Grade

Is either or both of your parents in the military or have either or both ever been in the military? If so, what branch of service and for how long?

_____

If either or both of your parents is or has been in the military, has either or both been deployed or is one of them currently deployed? If so, give deployment history including date(s) and location(s).

_____

_____

Current Medications

Name of medication Dose Frequency

_____

_____

_____

_____

Physician's name: _____

Are there any medical conditions I should know about?

_____

_____

_____

Continued
Client's name _____

If you are currently under the care of a psychiatrist, please give psychiatrist's name and phone number:

_____

Emergency contact _____Phone # _____

Referral source (who referred you or how did you hear about my services?)

_____

Current or previous counseling, treatment, and/or support group experience:

_____

_____

Any family or personal history of mental illness, alcoholism, substance abuse, suicidal thoughts, suicidal attempts or completed suicides I should know about?

_____

_____

_____

Are you having any suicidal thoughts right now?_____

Reason for seeking help now:

_____

_____

_____

_____

Please sign below and initial each previous page to verify that this is your/your child's information:

_____

Minor Child/Adolescent Parent/Legal Guardian's Name (please print)

_____ _____

Minor Child/Adolescent Parent/Legal Guardian's Signature Date