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Child/Minor Client Intake Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: ___ M ___ F

Address

School: _____

Grade: _____ Teacher: _____

Name of Parent(s)/Guardian(s)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent(s): ___ Single ___ Partnered ___ Married ___ Separated ___ Divorced

Is your child adopted? ___ Y ___ N **If YES, do(es) he/she/they know? ___ Y ___ N

Do you have an existing Guardianship, Custody and/or Visitation agreement regarding your child(ren)? ___ Y ___ N

*Note: You may be asked to provide a copy for your child(ren's) records

Contact Information

Mother(s)/Guardian(s) Preferred Phone: _____ (___ H, ___ W, ___ C)

Father(s)/Guardian(s) Preferred Phone: _____ (___ H, ___ W, ___ C)

I/We _____,
 as the responsible parent(s)/guardian(s), do hereby authorize counseling to be provided to the above named
 minor(s).

Signature: _____ Date: _____

Signature: _____ Date: _____

In order to obtain a more comprehensive understanding of your child and your family, please complete this form. Feel free to leave any question blank, but also consider that more information may allow me the opportunity to tailor the treatment plan to effectively meet your child's needs.

What prompted you to seek services?

How long has this been a problem? _____

Does your child/children view themselves as having a problem? ____ No ____ Yes

If YES, how would he/she/they describe the problem?

What specific symptoms/problems do you think are relevant? Please check all that apply

Physical

- Frequent complaints of: fatigue, headache, stomach ache, etc.
- Fidgeting/Unable to Relax
- Trembling/Shaking/Tremors
- Changes to Sleep Patterns
- Changes in Appetite/Eating Patterns

Mental

- Racing Thoughts
- Obsessions (thoughts, etc.)
- Suicidal Thoughts/Homicidal Thoughts
- Recurring, Distressing Dreams
- Difficulty Concentrating
- Hallucinations (Auditory, Visual, Etc) / Delusions (Detachment from Reality - Paranoid, Grandiosity, Etc.)
- Nightmares about Traumatic Experience(s)
- Frequent Worry Phobias/Unusual Fears about Specific Things
- Recurring, Distressing Thoughts about Trauma "Flashbacks" as if reliving Traumatic Experience(s)

Emotional

- Mood Swings
- Irritability
- Crying
- Clinginess/Separation Anxiety

Behavioral

- Change in friends/relationships
- Suicide Attempt(s)
- Drug Abuse
- Alcohol Abuse
- Lying
- Anger Outbursts
- Running Away
- Withdrawal
- Isolation
- Blaming
- Using/Manipulating
- Self Harm/Mutilation

In the space below, please feel free to further explain any of the above items

Parental/Family Information

Children in the home

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If parents are Separated or Divorced

How long have you been separated or divorced? _____

How old was/were your child(ren) at this time? _____

Has either parent remarried? ____ Y ____ N If Yes, how long ago? _____

How has/have your child(ren) responded to this?

Does your new spouse have children? ____ Y ____ N

If yes, how many? _____ (____ Girl(s), ____ Boy(s))

How has/have your child(ren) responded to this?

Special circumstances (e.g. raised by person other than parents, information about spouse/children not living with you, etc.)

Any other information I should have/know about your child/their relationship with you?
