auxano counseling

Adolescent Intake Parent(s)

PARENT/GUARDIAN INFORMATION

Name: _____ Date: _____

Home Address: _____ City, State, Zip: _____

Preferred Phone: _____

Email Address: _____

May we leave messages on your preferred phone? __ Yes __ No

May we send mail to this address? __ Yes __ No

FAMILY INFORMATION

Marital Status: __ Married __ Single __ Divorced __ Widowed __ Cohabitating

Date of Current marriage/divorce/cohabitation: _____ Number of Marriages: _____

Previously Married: __ Yes __ No If yes, when? _____ How Long: _____

Spouse/partner's name: _____ DOB: _____

Child(ren)'s Names: _____ DOB: _____ M F

_____ DOB: _____ M F

_____ DOB: _____ M F

_____ DOB: _____ M F

Occupation: _____ Highest Level of Education: _____

Name of other Custodial Parent: _____ Cell Phone: _____

Do you have consent from the other Custodial Parent for treatment of said child? __ Yes __ No

If no, this will be required by therapist before counseling can begin.

How much contact per month does the child have with his biological mother/father? _____

SPIRITUALITY

Do you believe in God or a Higher power? __ Yes __ No

What is your religious preference? _____

Are you a member of a Spiritual/Religious comminity? _____

If yes, what Spiritual/Religious community? _____

How much influence does your Sprituality have on a daily basis? __ Significant __ Moderate __ Some __ None

Complete all remaining information according to the child coming in for treatment

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GENERAL INFORMATION

Name: _____ DOB: _____ M F

The child is currently living with: _____

School: _____ Grade: _____

Extracurricular activities & interests: _____

MEDICAL HISTORY

How would you rate your child's current physical health? ____ Excellent ____ Good ____ Fair ____ Poor

Is the child currently complaining of any physical problems such as headaches or stomach aches? __ Yes __ No

If yes. please explain: _____

Previous hospitalizations for medical reasons: Date: _____ Reason: _____

Date: _____ Reason: _____

Please list any medical conditions or disabilities: _____

Please list any learning differences: _____

MEDICATIONS (including Psychiatric) Over-the-Counter & Prescription	**Dosage**

COUNSELING AND PSYCHIATRIC HISTORY

Has the child had previous counseling? __ Yes __ No If yes, when? _____ For how long? _____

For what reason? _____

Name and location of counselor: _____

Has the child ever been diagnosed with or treated for any type of mental illness? __ Yes __ No

If yes, which type? _____

Has anyone in the child's family ever been diagnosed with or treated for any type of mental illness? __ Yes __ No

If yes, which type? _____

REASONS FOR SEEKING HELP

What concerns about the child have brought you to counseling today? _____

_____

Where are these concerns causing the most problems for YOU? Please check all that apply:

__ Home __ Work __ Marriage __ Other

When are these concerns causing the most problems for the CHILD? Please check all that apply:

__ Home __ School __ Friends __ Other

When did the present concerns become a problem for the child? _____

What concerns about the child have been identified by others? _____

Please indicate which of the following areas are currently a problem for the child. Check all that apply:

__ Crying Spells
__ Excessive fears or anxieties
__ Difficulty being away from specific family members
__ Hearing voices
__ Getting into trouble at school/play
__ Temper tantrums
__ Difficulty falling asleep/inability to sleep at night
__ Decreased/increased appetite
__ Loss of interest in usual activities
__ Hyperactivity
__ Bullying or picking fights
__ Refusal to respond to authority
__ Nightmares
__ Obsessions/compulsions with specific activities
__ Lack of motivation
__ Lack of self confidence
__ Difficulty making or keeping friends
__ Other: _____

What do you hope to gain from counseling? _____

How did you hear about Auxano Counseling? _____