Date _____

Name _____ **Age** ___ Date of Birth __/__/__

Address _____ City _____ Zip _____

Email _____

Phone (primary) _____ Other _____

Emergency Contact (name) _____ (relation to minor)

_____

Emergency Contact's phone number _____

Family Info Father's Name_____ Mother's Name _____

Names/Ages of Siblings (Please list in order of age)

1. _____ Age ___
2. _____ Age ___
3. _____ Age ___
4. _____ Age ___
5. _____ Age ___
6. _____ Age ___

Counseling/Mental Health Background

Has child/teen received counseling before? Y/N Where?

_____

What issues were addressed? _____ # of visits? _____

Is child/teen currently on any medication for anxiety, depression, or addiction medicine, or other? Y/N If yes, what prescription(s)? _____

_____

Goals:

(Parents: please fill out this section if child is younger than 13. If they are 13 or older, have them fill out this section themselves.)

What goals do you wish to accomplish in counseling? _____

_____

In order to understand me: _____

What really hurts me: _____

I wish I could change: _____

My greatest regret is: _____

My greatest fear is: _____

My greatest joy is: _____

Additional Comments: _____