

ANTIOCH COUNSELING CENTER

Child Intake Form

CONFIDENTIAL

The following form, which will become part of your record, will help us get to know you more quickly. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name: _____ Date of Birth _____ Age ____ Sex ____

Present Address: _____
Number Street

City County State Zip Code

Phone: (____) _____ - _____ e-mail _____ Social Security #: _____

Race: _____ Who Suggested You Come In?: _____

Presently Living With: Parent(s) ____ Grandparent(s) ____ Aunt(s)/Uncle(s) ____ Other _____

Grade in School: _____ What School: _____

Where: _____ Number of Years at School: _____

Religious Affiliation: _____ Church: _____

Are you a member? Yes ____ No ____ Active ____ Inactive ____

Should There be an Emergency, Who Should We Call? Name: _____

Address: _____ Phone: _____

FAMILY MEMBERS

<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Last Completed Grade in School</u>	<u>Occupation if Out of School</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Describe any recent sickness or illness you have had that required medicine or going to the doctor: _____

Are you currently going to your doctor on a regular basis? Yes _____ No _____

When did you last go to your doctor? _____

Are you currently taking any prescribed medicine? Yes _____ No _____ If yes, what is it and how much to you take: _____

Have you been to a counselor before? Yes _____ No _____ If yes, when? _____

Who was it? Name: _____ Address: _____

Briefly tell us why you are here today: _____

Have there been times when the problem got better or disappeared? Yes _____ No _____

If yes, when? _____

What do you think helped? _____

Were there times when the problem was especially bad? Yes _____ No _____

If yes, when? _____

What made it bad? _____

Are there other people who play a major role in causing your problems or in helping you cope with your problems?

Yes _____ No _____

Explain briefly _____

Is there anything else that you believe might be important for your counselor to know at this time? _____

Using the scale below, please choose a number that describes your concern about each of the issues listed.

Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

- | | |
|------------------------------------------|-------------------------------------------|
| _____ Mad, Angry | _____ Religious/Spiritual Concerns |
| _____ Sad | _____ Can't Pay Attention |
| _____ School | _____ Thoughts of Hurting Yourself |
| _____ Eating Problems | _____ Trouble Making Decisions |
| _____ Afraid | _____ Unhappy Most of the Time |
| _____ Nervous, Jittery | _____ Use of Alcohol, Drugs |
| _____ Money Problems | _____ Use of Alcohol by Family Member |
| _____ Bullying, Problems with Classmates | _____ Use of Other Drugs by Family Member |
| _____ Physical Problems | _____ Parents' Work |
| _____ Problems with Other Children | _____ Worry |
| _____ Problems with Siblings | _____ Other (specify) _____ |
| _____ Problems with Parents | _____ |

I have read the Antioch Counseling Center Informed Consent Form and voluntarily request counseling services at the Counseling Center in accord with terms described on the Informed Consent Form.

Signature _____ Date _____

For clients age 17 and under, the signature or his/her custodial parent or guardian is required.

Parent/Guardian _____ Date _____

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION