STICK & STONE COUNSELLING SERVICES

CHILD/ADOLESCENT INTAKE FORM

DATE: _____

CLIENT:

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

D.O.B: _____ AGE: _____ **M / F** Click RACE: _____

PARENT/LEGAL GUARDIAN 1:

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

RELATIONSHIP TO CLIENT: _____

PARENT/LEGAL GUARDIAN 2:

LAST NAME: _____ FIRST NAME: _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

RELATIONSHIP TO CLIENT: _____

CUSTODY ARRANGMENT (Please circle)

JOINT CUSTODY ☐ SOLE CUSTODY ☐ LEGAL GUARDIAN ☐ LEGAL GUARDIAN(S) ☐

IS THERE A COURT ORDER? **Y/N** Click

DO BOTH PARENTS/GUARDIANS AGREE TO COUNSELLING FOR THE CHILD/ADOLESCENT? **Y/N** Click

If NO, please explain: _____

_____

_____

PHYSICIAN CARE

Is your child presently under a physician's care for their mental health? **Y/N** Click

Physician's Name: _____ Phone Number: _____

Has your child ever been diagnosed with a mental health problem? **Y/N** Click

If YES, please explain: _____

_____

_____

Is your child currently prescribed medications? **Y/N** * If yes, what are they medicated for?

NAME: _____ PERSCRIBED FOR: _____

NAME: _____ PERSCRIBED FOR: _____

NAME: _____ PERSCRIBED FOR: _____

REASON FOR SEEKING COUNSELLING:

Are any of the following conditions a concern to you at this time? (Please circle all that apply)

☐ ANXIETY	☐ CHRONIC FEAR	☐ STRESS	☐ LOSS OF FAITH IN GOD
☐ GRIEF	☐ ANGER	☐ GUILT	☐ SPIRITUAL CONFLICT
☐ DEPRESSION	☐ RAGE	☐ SUICIDAL THOUGHTS/FEELINGS	☐ UNHEALTHY WAYS OF COPING
☐ IRRATIONAL FEARS	☐ SELF-HARM BEHAVIORS	☐ BEHAVIORAL PROBLEMS	☐ RELATIONSHIP WITH PARENTS
☐ NERVOUSNESS	☐ SUBSTANCE ABUSE	☐ LOSS OF HOPE	☐ RELATIONSHIP WTH CHILDREN
☐ LONELINESS	☐ SELF-ESTEEM	☐ LOSS OF MEANING IN LIFE	☐ RELATIONSHIP WITH FRIENDS

If any of the following statements are true, please check the one(s) that apply:

☐ I have thoughts of harming myself or others

☐ These thoughts occur frequently

☐ I dwell on these thoughts and wonder if I can control them

☐ I have sought professional help for these thoughts and feelings in the past

On a scale of 1-10 (10 being high) please rate your level of anxiety over the past 2 weeks:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

On a scale of 1-10 (10 being high) please rate your level of anxiety over the past 6 months:

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

What is your reason for seeking counselling? _____

_____

_____

_____

_____

What do you expect from therapy? _____

_____

_____

_____

FAITH: (Please circle)

ATHEIST ☐ AGNOSTIC ☐ CHRISTIAN ☐ JEWISH ☐ MUSLIM ☐ HINDU ☐ OTHER ☐

Would you like faith incorporated into your treatment plan? **Y/N** Click

Thank you for taking the time to fill out this intake form. All information will be kept confidential.

If any questions or concerns arise, please feel free to discuss them with your counsellor.