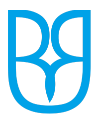

Intake Registration (12 and under)

Thank you for your commitment to the mental health of your child. This form helps me get some basic information, as well as give an opportunity for your child (referred below as "Client") to share some of what they have been experiencing.

Legal Guardian Information:		
First Name:	Last Name:	
Relationship to client: ☐ Biological parent ☐ Foster parent ☐ Adoptive parent ☐ Other (specify):		
Custody level: ☐ Joint custody & married Joint custody & separated ☐ Single parent, full custody ☐ Other (specify):		
Phone:	Email:	
Preferred contact (choose as many as you like): ☐ Call ☐ Text* ☐ Email* ☐ Leave voicemail ☐ Postal mail **Text and Email are not considered secure platforms for protected health information. Further information is provided in the* ***Outpatient Mental Health Consent***.		
Mailing address:	City:	Zip code:

What are your current concerns about your child's mental & behavioral health (check all that apply)?

- ☐ Often appears sad/down
- ☐ Often appears anxious/on edge
- ☐ Unable to focus
- ☐ Unable to sit still
- ☐ Difficulty making/keeping friends
- ☐ Physically aggressive (hitting, throwing things, etc.)
- ☐ Verbally aggressive (yelling, name-calling, etc.)
- ☐ Other concerns:
- ☐ History of trauma
- ☐ Has odd/atypical behavior
- ☐ Has strong mood swings
- ☐ Has difficulty understanding emotions
- ☐ Often defies rules & expectations
- ☐ Requires multiple reminders for tasks
- ☐ Has thoughts/actions of self-harm

Intake Registration (12 and under)

Client Information		
First name:	Last name:	Date of birth:
School: ☐ None		Grade level:
Doctor: ☐ None	Last seen by doctor (MM/YY):	
Previous/current diagnoses: ☐ None		
Previous/current medications: ☐ None		
Average amount of sleep: ☐ 0-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ 6-8 hours ☐ 8+ hours		
Nutrition/dietary concerns: ☐ None		
Previous counseling/therapy (location and length of treatment): ☐ None		

Intake Registration (12 and under)

These questions are specifically for the client.

1. What is your favorite treat? ____________________________

2. In general, how are you feeling right now? (circle a number)

1	2	3	4	5	6	7
Terrible			Ok/"Meh"			Great!

3. Have you been feeling like any of these words lately? (circle all that apply)

Depressed	Inspired	Worn out	Needing control
Anxious	Joyful	Stiff	Needy
Confused	Loved	Stressed	Unsure
Mood swings	Anger	Unfocussed	Irresponsible
Irritability	Weak	Lots of thoughts	Guilty
Hopeless	Strong	Obsessive	Addicted
Scared	Tired	Out of control	Day dreamy

4. What would your dream life be like? If you could change anything about your life, what would you change?

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