DEBBI MOLNAR, LMFT, LPCC

Licensed Marriage & Family Therapist (#MFC 49600)

INTAKE (CHILDREN & ADOLESCENTS)

All the information provided in this intake is confidential and cannot be released without your consent.
It is important you take the time to answer the questions as thoroughly as possible.

Client Information

First Name _____ Last Name _____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____ Can I Leave A Message? ❑ Yes ❑ No

Cell Phone (_____) _____ _____ Can I Leave A Message? ❑ Yes ❑ No

Email_____ Social Security #_____-_____-_____

Date of Birth _____/_____/_____ Age:_____

Emergency Contact _____ Relationship _____

Home Phone (_____) _____ Cell Phone (_____)_____

School_____ Grade _____

Responsible Party Information

First Name _____ Last Name _____

Relationship to Client_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Social Security #_____-_____-_____

Date of Birth _____/_____/_____ Age _____ Sex: ❑ Male ❑ Female

Referral Information

How did you hear about my services?_____

Is it okay to contact this person to thank them for the referral? ❑ Yes ❑ No Phone _____

Signature of Client or Responsible Party _____ Date _____

Family-of-Origin Information

Parent (1) First Name _____ Last Name _____

Relationship to Client _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Age _____

Occupation _____

Employer _____

Level of Education Completed _____ Degree Obtained _____

Health Problems _____

Medications _____

Describe Relationship with Client _____

_____

Parent (2) First Name _____ Last Name _____

Relationship to Client _____

Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Age _____

Occupation _____

Employer _____

Level of Education Completed _____ Degree Obtained _____

Health Problems _____

Medications _____

Describe Relationship with Client _____

_____

Other family member's name, age, school/work, living/deceased, if deceased cause of death, and a description of the relationship.

Stepfather _____

Stepmother _____

Sibling _____

Sibling _____

Sibling _____

Sibling _____

Sibling _____

Current Family Structure

Please list all individuals who currently live in the home. Include any information about custody arrangements for separated/divorced parents. Please include person's name, age, and a description of the relationship.

_____

_____

_____

_____

_____

_____

Parents Relationship Information

Current Relationship Status (check one):

❑ Single ❑ Partnered ❑ Engaged ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Date of Marriage _____ Date of Separation_____ Date of Divorce _____

How would you describe the relationship?_____

_____

_____

_____

If divorced, what are the legal child custody arrangements? (Please provide documentation) _____

_____

_____

_____

Medical/Mental Health Information

Please list all diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures and any other medical conditions your child has had.

Age	Illness/Diagnosis	Treatment	Result

Does your child have any current health issues? (explain) _____

_____

_____

List all medications your child is currently taking: (prescribed, over the counter, and others)

Medication	Dosage	Taken for	When started	Prescribed by

List current physician(s) or medical practitioners whose care your child is under:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Has any member of your child's family been treated for

Schizophrenia: ❑ Yes ❑ No If yes, who? _____

Bipolar Disorder: ❑ Yes ❑ No If yes, who? _____

Major Depression: ❑ Yes ❑ No If yes, who? _____

Substance Abuse or other Addictions: ❑ Yes ❑ No If yes, who? _____

_____

Other mental health issues in your child's family of origin _____

_____

_____

Please list any major family health issues (include family member and issue) _____

_____

_____

_____

Has your child ever received psychiatric or psychological services before? (check one): ❑ Yes ❑ No

(If yes, please list his/her age at the time of treatment, the length of treatment, the focus of treatment, if a diagnosis was given, what the diagnosis was, if you felt the diagnosis was accurate and the reason treatment was terminated.)

_____

_____

_____

Has your child ever thought about, discussed or attempted suicide?): ❑ Yes ❑ No If yes, when? _____

If so please describe_____

_____

Has your child been the victim of or witnessed:

Domestic Violence/Abuse: ❑ Yes ❑ No If yes, who? _____

Physical Abuse: ❑ Yes ❑ No If yes, who? _____

Emotional Abuse: ❑ Yes ❑ No If yes, who? _____

Assault: ❑ Yes ❑ No If yes, who? _____

If the answer to any of the above questions is "yes" was the abuse reported? ❑ Yes ❑ No

Is it still going on? ❑ Yes ❑ No

Social/Other Information

Academic Abilities/Difficulties _____

_____

_____

Learning Disabilities (When diagnosed, by who, diagnosis, how it affected child) _____

_____

_____

Describe your child's relationship with friends _____

_____

_____

What are your child's current stressors?_____

_____

_____

Name five of your child's positive attributes_____

_____

_____

Please describe what prompted you to make this appointment _____

_____

_____

Symptoms/Problem Checklist

Please check any of the following problems/issues which you feel apply to you:

- ❑ Depression
- ❑ Hopelessness
- ❑ Loneliness
- ❑ Grief/Loss Issues
- ❑ Anxiety/Nervousness
- ❑ Fear
- ❑ Suicidal Thoughts
- ❑ Racing Thoughts
- ❑ Separation Anxiety
- ❑ Obsessive Thoughts
- ❑ Compulsions
- ❑ Unorganized
- ❑ Messy
- ❑ Temper/Anger
- ❑ Impulse Control Issues
- ❑ Irritability
- ❑ Self Control
- ❑ Concentration/Focus
- ❑ Memory Issues
- ❑ Self Criticism
- ❑ Low Self Esteem
- ❑ Guilt
- ❑ Tired/Weak
- ❑ Lack of Motivation
- ❑ Difficulty Making Decisions
- ❑ Overwhelm
- ❑ Issues with energy
  - ❑ Lack of Energy
  - ❑ Too Much Energy
- ❑ Difficulty with Change
- ❑ Transition Issues

  Specify_____

  _____
- ❑ Trauma

  Specify _____

  _____
- ❑ Issues with Sleep
  - ❑ *Difficulty falling asleep*
  - ❑ *Difficulty staying asleep*
  - ❑ *Sleeping too much*
  - ❑ *Nightmares/Terrors*
- ❑ School Issues
- ❑ Health Issue(s)

  Specify _____

  _____
- ❑ Health Issue with a Family Member

  Specify _____

  _____
- ❑ Disabilities

  Specify _____

  _____
- ❑ Learning Issues

  Specify _____

  _____
- ❑ Sexual Identity Issues
- ❑ Difficult with Social Cues
- ❑ Difficulty Making Friends
- ❑ Difficulty Keeping Friends
- ❑ Self Destructive Behavior
  - ❑ *Cutting*
  - ❑ *Picking (Skin, Nails, Hair)*
  - ❑ *Other* _____
- ❑ Relationship Issues
  - ❑ *Parents*
  - ❑ *Siblings*
  - ❑ *Friends*
  - ❑ *Lack of Relationships*
  - ❑ *Other* _____
- ❑ Issues with Abuse/Addiction
  - ❑ *Alcohol*
  - ❑ *Drugs*
  - ❑ *Gambling*
  - ❑ *Spending*
  - ❑ *Internet/Electronics*
- ❑ Body Image Issues
  - ❑ *Weight Issues*
  - ❑ *Obsessive Thinking re: Food/Weight*
  - ❑ *Binging*
  - ❑ *Purging*
  - ❑ *No Appetite*
  - ❑ *Too Much Appetite*
- ❑ Personality Traits
  - ❑ *Shy*
  - ❑ *Assertiveness*
  - ❑ *Judgmental*
  - ❑ *Secretive*
  - ❑ *Suspicion*
  - ❑ *Jealousy*
  - ❑ *Other* _____

    _____
- ❑ Other Issues Not Mentioned

  Specify _____

  _____

  _____

  _____

  _____

  _____

  _____

What are your goals for therapy?

Is there anything else you would like me to know?

To the best of my knowledge, the information provided in this intake is correct. I will notify you of any changes in this information.

Client Signature _____

Printed Client Name _____ Date _____

Signature of Parent/Guardian _____ Date _____

Printed Name _____ Relationship to Client _____

Signature of Parent/Guardian _____ Date _____

Printed Name _____ Relationship to Client _____