SERENITY COUNSELING SERVICES

YOUTH INTAKE FORM

Child's Name: _____ Age: _____ DOB: _____

Sex: ☐ Male ☐ Female **Race**: _____

Mother's Name: _____ Age: _____ DOB: _____

Address (City, State and Zip):

_____

_____

Marital Status: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____

Father's Name: _____ Age: _____ DOB: _____

Address (City, State and Zip): _____

_____

Marital Status: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____

Complete if the legal guardian or custodian is someone other than the child's parents.

Step Parent/Guardian: _____ Age: _____ DOB: _____

Address (City, State and Zip): _____

_____

Marital Status: _____

Phone: (H) _____ (W) _____ (C) _____

Email: _____

Insurance Details

Is the child covered under health insurance? ☐ Yes ☐ No

Insurance Company: _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ ID Number: _____

Group Number: _____ Policy Holder SSN: _____

How were you referred for services? _____

History of Problem

Please describe what concerns you have regarding your child:

_____

_____

_____

How long has the problem existed? _____

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, or financial problems, in the last several years?

_____

_____

_____

What attempts have been made to resolve the difficulties?

_____

_____

_____

Please indicate the symptoms that the child is currently experiencing. Please indicate the severity and duration.

Severity of Symptoms	**None**	**Mild**	**Moderate**	**Severe**
	0	**1**	**2**	**3**

Symptom	**Y/N**	**Severity**	**How long?**
Sadness or Depression			
Suicidal Thoughts			
Sleep Problems			
Changes in Appetite			
Weight Change			
Inability to Concentrate			
Obsessive thoughts			
Tension and Anxiety			
Panic Attacks			
Memory Problems			
Compulsive Behaviors			
Feelings of Hostility			
Acts of Violence			
Social Isolation			
Strange Thoughts			
Stomach Aches			
Head Aches			
Bed Wetting			
Phobias			
Other:			

Parent Information

Are there any other agencies involved with the family (DCFS, Child Welfare, Courts, etc.)?

_____

For Parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)

_____

_____

Is ex-spouse (biological parent) aware that you are bringing their child to counseling?

☐ Yes ☐ No

If not, please explain.

_____

_____

Is the child adopted? ☐ Yes ☐ No

If adopted, does child know of adoption? ☐ Yes ☐ No

What age was your child at the time of adoption? _____

Mother's Occupation: _____ Employment status: _____

Employer's name: _____

Significant medical problems:

_____

Serious illnesses, accidents, or surgeries in the past:

_____

_____

Current and past psychiatric treatment or counseling:

_____

Currently prescribed medications:

_____

Current alcohol/drug use (amount, how often, intoxication frequency):

_____

History of alcohol/drug use? _____

Father's Occupation: _____ Employment status: _____

Employer's name: _____

Significant medical problems:

_____

Serious illnesses, accidents, or surgeries in the past:

_____

_____

Current and past psychiatric treatment or counseling:

_____

Currently prescribed medications:

_____

Current alcohol/drug use (amount, how often, intoxication frequency):

_____

History of alcohol/drug use? _____

Step Parent/Guardian Occupation: _____

Employment status: _____

Employer's name: _____

Significant medical problems:

_____

Serious illnesses, accidents, or surgeries in the past:

_____

_____

Current and past psychiatric treatment or counseling:

_____

Currently prescribed medications:

_____

Current alcohol/drug use (amount, how often, intoxication frequency):

_____

History of alcohol/drug use? _____

Child's Information

Child lives with: _____

School: _____ Grade: _____

Significant medical problems:

_____

_____

Serious illnesses, accidents, or surgeries in the past:

_____

_____

_____

Current and past psychiatric treatment or counseling:

_____

_____

Currently prescribed medications:

_____

Current alcohol/drug use (amount, how often, intoxication frequency):

_____

History of alcohol/drug use? _____

History of arrest: _____

Primary Care Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

SUBMIT