LSC
LIVING SUCCESS CENTER
A Pathway to Mental Health & Wellness

Minor/Child Intake Form

General Information

Name of person filling out this form: _____ Relationship to child: _____

Minor's Name: First _____ Middle _____ Last _____ Date: _____

Age: _____ Date of Birth: _____ Ethnicity: _____
In years mm/dd/yyyy please list as you would like

Address: _____
Street City State Zip Code

Phone: _____
Home Cell Work Email

What is the best number to reach you at: ___Home ___Cell ___Work May we text? Yes or No

Who is the best person to contact regarding your child's/minor's therapy sessions: _____
Name of Contact Person

Child/Minor's Schoo1: _____ Grade: _____

Monthly Household Income: _____ Number of People in Household: _____

Family Information

Mother's Name: _____ Age: _____ Occupation: _____
First Middle Last

Father's Name: _____ Age: _____ Occupation: _____
First Middle Last

Guardian's Name: _____ Age: _____ Occupation: _____
First Middle Last

Step Mother's Name: _____ Age: _____ Occupation: _____
First Middle Last

Step Father's Name: _____ Age: _____ Occupation: _____
First Middle Last

Child/Minor's Parent's are: ___Married ___Divorced __Domestic Partnership ___Separated ___Other: _____

If parents are divorced) who has legal custody? ___Mom ___Dad ___Joint __0ther: _____
Please Specify

- ***Note – If seeking services for your child and you are divorced, you must show proof of custody status and/or ability to make legal/medical decisions for your child. If there is joint custody, the other parent must give written permission for the child to receive services.***

Child/Minor was child number ___ in a family of _____children. Child/Minor was adopted: Yes or NO

Please list siblings by age: (include step, adopted and half siblings)						
Name	Age	Sex	Education/Grade	Living with Whom?	Relationship to Child/Minor	Special concerns

Please list any other person(s) living with child/minor:			
Name	Age	Relationship.	Special Concerns

Family History - indicate if any of the following is true for any of the following family members						
	Child/Minor	Mother	Father	Sibling	Grandparent	Other significant family member - Please Specify:
Depression						
Suicide						
Suicide Attempt						
Alcohol Problem						

Drug Problem						
Mental/Emotional problem						
Abuse						
Other Major Trauma (i.e. rape, combat, etc.)- Please specify:						

Medical History

Name, Address, & Phone # of Physician:_____

_____

Date of Last Exam:_____ General Health Assessment: _____

Any current illness(es) being treated? Yes or No Specify:_____

Complications during pregnancy or child birth? Yes or No Specify:_____

Please circle any of the following medical conditions the child/minor has or had in the past & give age of occurrence:

Heart Trouble	Accident(s)	Fainting/Dizziness
Diabetes	Shortness of Breath	Stomach Problems
High Fevers	Bedwetting/Soiling	Neurological Disease
Kidney Trouble	Asthma	Other Childhood Disease(s)
Head Injury	Sleep Difficulty	Meningitis/Encephalitis
Ear Infections(s)	Eye Problems	Allergies
Frequent/Severe Headaches	Seizures/Convulsions	

Please list any other serious illness, injury, or surgery the child/minor has had:

Type of illness/injury/surgery	**Name, Address, & Phone # of Treating Physician**	**Date of illness/injury/surgery**

List all medications child/minor is currently taking (including non-prescription such as vitamins, etc.):

Name of Medication:	Dosage & How Many Times a Day:	Prescribed by:

Please list any prior psychotherapy the child/minor has received:

Name of Counselor/Therapist	Address & Phone #	Date(s) of Service

Please list any hospitalization for psychiatric reasons the child/minor has had in the past:

Name of Hospital	Address & Phone #	Date(s) of Hospitalization

Please provide names of people we can contact in case of an emergency:

Name of Person	Phone #	Relationship to You

Problem Areas of Concern

Please check any of the following problem area that led you to seek counseling for this child/minor along with level of concern:

For example, if you came in for issues related to "Bullying" you would check that category and put the number in level of concern. The levels are as follows:

1= Area of concern but generally handling the situation
2= Moderate concern for me and I'm ready to seek help
3= Enough of a problem as it is beginning to affect my functioning in *at* least 1 area of my life (job, home, relationship, school, legal, etc.)
4= Problem is affecting multiple (2 or more) areas of my life and/or my day to day functioning
5= Severe problem, affecting all aspects of my life and limits my ability *to* function day to day

Specific Problem Area	Check if Problem	Level of Concern	Specific Problem Area	Check if Problem	Level of Concern
Adult Relation Issues			Hurts Animals		
Adoption			Legal Issues		
Alcohol or Drug Use			Loneliness		
Anger/Frustration			Loss of Appetite		
Anxiety/Excessive Worry			Loss of Energy		
Bitterness/Resentment			Loss of Memory		
Bullying			Loss of Trust		
Child Abuse			Suicidal Attempts		
Depression/Sadness			Medication/Drug Issues		
Difficulty with Directions			Moving		
Disrespects Authority			Mood Swings		
Divorce of Parents/Caregivers			Discipline Issues in Home		
Irritability			Discipline Issues at School		
Poor Self-Communication			Panic Attacks		
Nail Biting			Disrespects Authority		
Wetting /Soiling Underwear			Physical Abuse		
Poor Concentration/Focusing			Religion/Faith Issues		
Crisis/Traumatic Event			Separation		
Death or Loss of Loved One			Sexual Abuse		
Eating Disorder			Sexual Relations		
Envy/Jealousy			Suicidal thoughts		
Family Issues			Self-esteem		
Sibling Discord			Rejection from Peers		
Shyness			Unemployment		
Fear/Phobias			Other: (Please List Below)		
Truancy					
Forgiveness					
Friendship/ Peer Problems					
Guilt/Shame					
Health/Medical Issues					
Honesty					
Academic Issues					
Incest					
Destroys Property					
Plays with Matches/Fire					
Insomnia					
Issues surrounding sexual orientation					

Please write a brief statement about the problem(s) or areas of concern that brought you into counseling:

What do you hope to gain from coming to counseling?

Have things improved in any way since you made your initial appointment? (Circle one) YES or NO

If so how? Please explain:

Appointment Cancellations Policy:

If an appointment is cancelled or missed without 24 hours prior notice. a regular charge will be made and carried on in your balance. Please note any Monday appointments must be cancelled by noon on Friday.

Whom may we thank for referring you to us? _____

This form was completed by:_____ on_____
Signature Date

445 E. 17th Street, Suite E • Costa Mesa, CA 92627
Phone: (949) 645-4723 • Fax: (949) 423-7728 • Web Site: www.livingsuccesscenter.org
A Nonprofit Organization Serving Orange County

Client Initial _____