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:_____

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

Insurance:_____

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

		During the past **TWO (2)WEEKS**, how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Clinician Use Only** (Highest Domain Score)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Was your child worried about health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping- that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost their temper?	0	1	2	3	4	
VII.	9.	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3		
	10.	Sleeping less than usual but still has lots of energy?	0	1	2	3	4	
VIII.	11.	Did your child feel nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	The child couldn't do things that they wanted to or should have done because they made them feel nervous?	0	1	2	3	4	
IX.	14.	Said that they heard voices-when there was no one there-speaking about them or telling them what to do or saying bad things to them?	0	1	2	3	4	
	15.	Said that they had a vision when they were completely awake – that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that they had thoughts that kept coming into their mind that they would do something bad or that something bad would happen to them or to someone else?	0	1	2	3	4	
	17.	Said they felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things they touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that they had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
	In the past **TWO (2) WEEKS**, has your child…							
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No	☐ Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No	☐ Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No	☐ Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No	☐ Don't Know		
XII.	24.	In the PAST TWO (2) WEEKS, have they talked about wanting to kill themselves or about warning to commit suicide?	☐ Yes		☐ No	☐ Don't Know		
	25.	Have they EVER tried to kill themselves?	☐ Yes		☐ No	☐ Don't Know		

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

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