Positive Change
for Teens and Families

# Parent/Guardian Intake Form

Please provide the following information and answer the questions below.
The information you provide here is protected and confidential. Please bring this completed form to your first appointment.

Name:_____
(Last) (First) (MI)

Relationship to Client: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email:_____
**Please note: email correspondence is not considered to be a confidential method of communication*

How would you prefer to be contacted? _____
**Please place a star next to each phone number where we can leave a message*

How were you referred to my practice? _____

Please list the top three reasons you bought your child here for evaluation/ treatment:

1. _____

2. _____

3. _____

Who and/or what do you turn to in times of stress?

_____

_____

Do you consider yourself to be spiritual or religious? yes ☐ no ☐

If yes, describe your spiritual faith or belief:

_____

_____

In reference to your child, please answer the following questions:

1. How would you rate his/her physical health?

Poor Unsatisfactory Satisfactory Good Very Good

2. How would you rate his/her current mental health?

Poor Unsatisfactory Satisfactory Good Very Good

3. Please rate his/her current appetite.

Poor Unsatisfactory Satisfactory Good Very Good

4. Please rate his/her current mood.

Poor Unsatisfactory Satisfactory Good Very Good

5. What words would you use to describe his/her mood?

_____

**Family Mental Health History:**

In the section below, please note if there is a family history of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, sister etc…)

| **Condition** | **Please Circle** | **List Family Member(s)** |
|---|---|---|
| Alcohol/Substance Abuse | yes/ no | _____ |
| Autism | yes/no | _____ |
| Anxiety | yes/ no | _____ |
| Depression | yes/ no | _____ |
| Domestic Violence | yes/ no | _____ |
| Eating Disorders | yes/ no | _____ |
| Learning Disabilities | yes/ no | _____ |
| Obesity | yes/ no | _____ |
| OCD/ Phobias | yes/ no | _____ |
| Physical/ Sexual Abuse | yes/ no | _____ |
| Schizophrenia | yes/ no | _____ |
| Suicide Attempts | yes/ no | _____ |
| Suicide Completion | yes/ no | _____ |
| Other: _____ | Family Member: _____ | |

**Family Medical History:**

| Condition | Please Circle | List Family Member(s) |
|---|---|---|
| Acne | yes/no | _____ |
| Alzheimer's | yes/no | _____ |
| Arthritis | yes/no | _____ |
| Asthma | yes/no | _____ |
| Autoimmune Disease | yes/no | _____ |
| Brain Injury | yes/no | _____ |
| Cancer | yes/no | _____ |
| Diabetes Mellitus | yes/no | _____ |
| Down Syndrome | yes/no | _____ |
| Epilepsy | yes/no | _____ |
| Gastrointestinal Disease | yes/no | _____ |
| High Blood Pressure | yes/no | _____ |
| Heart Disease | yes/no | _____ |
| Infectious Diseases | yes/no | _____ |
| Migraines | yes/no | _____ |
| Obesity | yes/no | _____ |
| Other Illness: _____ | | _____ |

Additional Information:

Are there any significant life changes or stressful events you experienced recently?

_____
_____
_____

What are your child's top three strengths?

_____
_____
_____

What are the three things you would like your child to work on in counseling?

_____
_____
_____

Thanks very much for taking the time to complete this form.

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