Austin Wellness

Austin Wellness, PLLC
www.austin-wellness.com
10010 Anderson Mill Rd.
Austin Texas 78750
512-257-0050

MINOR INTAKE FORM

Please provide the following information for my records. All information you provide here is held to the same standards of confidentiality as our therapy. Please fill out this form prior to our first session.

Client Name: _____ Date: _____
Age: _____ Birth Date: ____/____/_____

Parent/Guardian Name(s) :_____
Address: _____ City: _____ Zip Code: _____
Referred By:_____ May I thank them for the referral? Yes | No
Emergency Contact: _____ Relation: _____ Phone #: _____
Preferred email contact: _____

Minor: In your own words, please state the nature of the main problem: _____
_____

Minor: How would you rate how serious this problem feels to you now? (Circle one)

1 2 3 4 5
Mildly Upsetting Extremely Serious

Parent: In your own words, please state the nature of the main problem: _____
_____

Parent: How would you rate how serious this problem feels to you now? (Circle one)

1 2 3 4 5
Mildly Upsetting Extremely Serious

What would you like to accomplish through counseling? _____

FAMILY INFORMATION

Father Name: _____ Age: _____ Occupation: _____
Mother Name: _____ Age: _____ Occupation: _____

Marital Status of Parents: Single | Married | Divorced | Separated | Living Together | Other:_____
Briefly describe minor's relationship with Father: _____
Briefly describe minor's relationship with Mother: _____
If divorced, please specify minor's age at divorce and circumstances surrounding divorce:_____
_____
Custody Arrangement: _____
Brothers' and Sisters' first names and ages:_____
Please explain if any member of the family (immediate or extended) has ever suffered from a medical or mental health condition: _____
Please mention any history of domestic violence, child abuse or sexual abuse in the family:_____
_____
Please comment on any history of alcohol or drug use in the family: _____
_____

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MINOR'S DEVELOPMENTAL HISTORY

Parents' attitudes toward having children:_____
Complications with pregnancy? Yes | No (If yes, please describe): _____
Premature Birth? Yes | No (If yes, please describe): _____
Age When: Crawled _____ Walked _____ Spoke First Word _____ Spoke First Sentence _____
Developmental Delays? Yes | No (If yes, please describe): _____
Please list any known significant life changes or traumatic events: _____

MINOR'S EDUCATIONAL HISTORY

School Grade _____ Name of current school:_____
Type of Class: Regular | Accommodations/Special Education | Accelerated/Advanced | Gifted/Talented
School Problems? Yes | No (If yes, please describe): _____
Skipped a grade? Yes | No (If yes, please describe): _____
Held back a grade? Yes | No (If yes, please describe): _____

MINOR'S CURRENT FUNCTIONING

Behavioral Problems Yes | No (If yes, please describe): _____
Problems with Parents Yes | No (If yes, please describe): _____
Problems with Siblings Yes | No (If yes, please describe): _____
Problems with Peer Relationships Yes | No (If yes, please describe): _____
Substance Use or Abuse Yes | No (If yes, please describe): _____
Sexually Active Yes | No (If yes, please describe): _____
Any Cultural Considerations Yes | No (If yes, please describe): _____

MINOR'S SYMPTOMS (Please check all that apply)

	Never	Seldom	Sometimes	Often	Comments
Sleep problems	☐	☐	☐	☐	_____
Headaches	☐	☐	☐	☐	_____
Phobias/Fears	☐	☐	☐	☐	_____
Nervous/worry	☐	☐	☐	☐	_____
Loss of temper	☐	☐	☐	☐	_____
Mood swings	☐	☐	☐	☐	_____
Depressed mood	☐	☐	☐	☐	_____
Attention/focus	☐	☐	☐	☐	_____
Hyper/restless	☐	☐	☐	☐	_____
Stomach issues	☐	☐	☐	☐	_____
Appetite concerns	☐	☐	☐	☐	_____
Pain	☐	☐	☐	☐	_____
Fatigue	☐	☐	☐	☐	_____

MINOR'S TREATMENT/COUNSELING HISTORY

Has minor ever had any previous counseling or psychotherapy? Yes | No (If yes, please list from most recent):

Dates	Problem	Therapist & Location	Helpful?
			Yes | No
			Yes | No

Has minor ever attempted suicide? Yes | No (If yes, when?): _____
Has minor ever been hospitalized for psychiatric reasons? Yes | No (If yes, when?): _____

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MINOR'S MEDICATION HISTORY (Please check all that apply)

	Never	Seldom	Sometimes	Often	Comments
Pain Relievers	☐	☐	☐	☐	_____
Sleep Aids	☐	☐	☐	☐	_____
Allergy medicine	☐	☐	☐	☐	_____
Vitamins	☐	☐	☐	☐	_____
Psychiatric medication	☐	☐	☐	☐	_____

Other (please specify): _____

Please list all current medications and supplements:

Medication	Dose	Reason

Current Weight: _____ One Year Ago: _____ Maximum: _____ When? _____
Does minor exercise regularly? Yes | No If yes, How? _____
Does minor sleep well? Yes | No Amount (hours):_____ Easy to get to sleep? Yes | No
Physician / City / Date of last physical: _____ Phone #: _____

OTHER INFORMATION

Do you consider your family to be religious? Yes | No If yes, what is your faith? _____
Do you feel that your faith should be a significant part of your therapy? Yes | No If yes, please describe:
_____
If no, do you consider yourself to be spiritual? Yes | No If yes, please describe: _____
_____
Please describe minor's religious/spiritual status, if different than family: _____

What are minor's strengths/talents: _____
Who is supportive of minor outside of family? (best friend, teacher, coach) _____

Is there anything else you think would be helpful for me to know? _____
_____

Client Name (Print): _____Signature: _____Date: _____

Parent/Guardian Name (Print): _____ Signature: _____Date: _____

Signature of Therapist: _____ Date: _____