Freedom's Hope Counseling
Child Intake and Parent Consent

Name of Person Completing Intake Form: _____

Child's Name: _____ Date: _____

Guardianship:(select one) ☐Both Parents Equally | ☐Mother | ☐Father | Other: _____

Mother's Address:_____

Mother's Cell #: _____ Mother's Other Phone: _____

Father's Address:_____

Father's Cell #: _____ Father's Other Phone: _____

Step-Parents: _____

Child's Cell #:_____ May we leave a message at this phone? ☐Yes | ☐No

Child's Date of Birth: _____ Age: _____ Gender: _____

Race/Ethnicity: _____ Sexual Orientation _____

Does the child have siblings? ☐Yes | ☐No | How many? _____ # of Children living at home: _____

Referred by: _____ Have you had previous counseling? ☐Yes | ☐No

Is client currently receiving counseling elsewhere? ☐Yes | ☐No

What grade has child completed? _____ Is child passing all classes? ☐Yes | ☐No

Symptom Checklist (Check all that apply)

Anxiety: ☐Agitation | ☐Fatigue | ☐Irritability | ☐Poor Concentration | ☐Restlessness | ☐Sleep Disturbance | ☐Tension | ☐Dissociative Episodes | ☐Phobia

Depression: ☐Changes in Sleep | ☐Change in Appetite | ☐Psycho-motor Retardation | ☐Fatigue | ☐Hopelessness | ☐Change in Weight | ☐Suicidal Ideation | ☐Agitation | ☐Diminished Self-Esteem | ☐Feeling Sad/Down Most Days | ☐Excessive Guilt | ☐Not Enjoying Things You Used To

Delusions: ☐Grandiose | ☐Religious | ☐Paranoia | ☐Somatic | ☐Persecution | ☐Self Deprecating

Hallucinations: ☐Auditory | ☐Smell | ☐Touch | ☐Visual

Sense of Time: Have you ever felt like you lost time? ☐Yes | ☐No

Panic: ☐Heart Palpitations | ☐Shortness of Breath | ☐Chest Pain | ☐Nausea | ☐Dizziness | ☐Chills | ☐Hot Flashes

Mania: ☐Grandiosity | ☐Pressured Speech | ☐Increased Activity | ☐Euphoria | ☐High Risk Behaviors | ☐Decreased Sleep | ☐Racing Thoughts | ☐ Irritability | ☐Impulsivity

Impulsive Behavior: ☐Physical Aggression | ☐Attachment Issues | ☐Damage Property | ☐Maladaptive Gambling | ☐Pulling Hair Out | ☐Rageful Episodes | ☐Stealing | ☐Verbal Aggression | ☐Legal Problems | ☐Fire Setting

Abuse/Trauma: ☐Spiritual Abuse | ☐Authoritative Abuse | ☐Verbal Abuse | ☐Physical Abuse | ☐Neglect | ☐Psychological Abuse | ☐Sexual Abuse | ☐Sibling Abuse | ☐Bullying; Age(s) of abuse: _____ ☐Avoiding Stimuli Associated with Trauma | ☐Hyper-arousal | ☐Flashbacks

Eating: ☐Intense Fear of Gaining Weight | ☐Distorted Body Image | ☐Binge eating | ☐Absence of Menstruation | ☐Induced Vomiting | ☐Laxative Abuse | ☐Diuretic Abuse | ☐Excessive Exercise | ☐Fasting | ☐Compulsive Eating | ☐Weight Gain | ☐Weight Loss

Learning/Attention: ☐Difficulty Writing | ☐Difficulty Reading | ☐Dyslexia | ☐Difficulty with Math | ☐Difficulty with Verbal Expression | ☐Hyperactivity | ☐Poor Attention | ☐Truancy

How would you describe client's P**hysical Health** at present?

☐Poor | ☐Unsatisfactory | ☐Satisfactory | ☐Good | ☐Very Good.

Please list any persistent physical symptoms or health concerns (e.g.: chronic pain, diagnosis, etc.)

_____

Is child having any problems with sleep? _____. If yes, please explain? _____

_____

Has child had thoughts of suicide in the past 3 months? ☐Yes | ☐No

If yes, please describe: _____

Has client had thoughts of or do you participate in non-suicidal self-harm? (i.e.: cutting) ☐Yes | ☐No

In the past year, has child experienced life changes or stresses? ☐Yes | ☐No

If yes, please explain: _____

Drug or Alcohol:

Is client taking any prescribed psychiatric medications (anti-depressants; anti-anxiety, etc.)?

If yes, please list: _____

Does client regularly use alcohol? _____ If yes, how many drinks in a 7-day period? _____

In a typical month, how often does client have 4 or more drinks in a 24-hour period? _____

How often do you engage in recreational drug use? (Select One)

☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

What Substances does client use? _____

Does client use Marijuana? _____ If yes, THC value? _____ How many uses per day? _____

Has client ever felt that substance use (alcohol or drug) was a problem? _____

Has anyone ever told client they were concerned about substance use? _____

Please check the statements that apply to child:

☐ Child does not have close friends to talk to about personal issues.

☐ Child has a good social support system.

☐ Child's relationship with my family is satisfactory.

☐ Child has difficulty handling stress.

☐ Child has difficulty expressing my emotions.

☐ Child often gets extremely angry.

☐ At times, child has acted in a violent manner.

☐ Child is having academic or work issues.

☐ Child has suffered a recent loss. Please explain: _____

_____

_____

List any significant history that is still affecting child today: _____

_____

_____

_____

Has client ever been involved with the legal system or Child Protective Services? ☐ Yes | ☐ No

If Yes, please explain, _____

Were there any problems with mother's pregnancy or delivery of child? _____

Please explain, _____

Did mother of client have a miscarriage prior to child's birth? _____

Did child's mother have post-partum depression? _____

Were there any significant illnesses in the family that could separate child from parents or any possible disruption in child/parent attachments? _____

Strengths and Goals:

What are some of child's strengths? _____

_____

_____

What would parent/child like to accomplish in counseling? Please list your goals: _____

_____

_____

_____

Record Keeping & Limitations to Legal Action:

Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client 18-years of age or older, must file a complaint or other notice with the licensing board within 7 years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of 7 years commencing on the date of termination of services or on the date of last contact with the client, whichever is later. When the client is a child, the records must be retained for a period of 7 hears commencing either upon the last day of treatment or when the child reaches 18 years of age, whichever comes later, but in no event shall records be kept for more than 12 years.

Emergency Contact:

Please give the name and phone number of an Emergency Contact:

Name: _____ Phone: _____

Do we have your permission to contact this person if we feel necessary? ☐ Yes | ☐ No

Parent Consent to Treat Child

I _____ the legal guardian of _____
consent to mental health treatment at Freedom's Hope Counseling, LLC.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

If you are unable to keep your scheduled appointment, please notify us at (970) 829-1968 at least 24 hours prior your appointment. Thank you.