Olive Branch Counseling and Training

31320 IH 10 West, Boerne, TX 78006
Office: (210) 564-4310 Fax: (830)755-2369

Personal History Intake Packet for Minors

Client Name: _____ Date: _____

Gender: □ M □ F Date of birth: _____ Age: _____

Grade in school: _____ Name of school: _____

Forms completed by (if someone other than client): _____

Address: _____ City: _____ Zip: _____

Phone (home): _____ Work: _____ Cell: _____

Social Security Number: _____ * This is only necessary when filing with insurance.

Email Address: _____

May we contact you by: (please check all that apply)

□ Phone call □ Leaving a voicemail message □Text Message □ Email □ U.S. Postal Mail

Emails

While every precaution is taken to ensure confidentiality on the internet, emails can be hacked and information can be seen by unwanted parties. Please initial to indicate your understanding of the associated risks with email communication and your acceptance of receiving emails. _____

Primary reason(s) for seeking services for a minor

□ Addictive Behaviors
□ Trauma History
□ Anger management
□ Anxiety
□ Career/Education
□ Grief & Loss
□ Separation/ Divorce
□ Other: _____
□ Communication Skills
□ Coping
□ Depression
□ Behavioral Concerns
□ Fear/Phobias
□ Giftedness
□ Social struggles
□ Personal Growth
□ Parenting
□ Relationship concerns
□ Sexual Concerns
□ Sleeping Problems
□ Special Needs
□ Family Conflict

While I am happy to help, please know that a referral to a different counselor/therapist may be in order to best meet your child's needs. I will happy to help you set that up if necessary.

_____Please initial here to indicate your understanding of the limits of my specialties and the ethical obligation to make referrals when there is a mismatch between need and services.

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Please indicate who the services are for: _____.

Relationship to you: ___ Child ___ Step Child ___ Adopted Child ____ Grandchild ____ Foster Child ___ Other: _____

What are your goals for the child's therapy? Please include child's input as appropriate.

_____

_____

_____

Do your child feel suicidal at this time? □ Yes □ No, if Yes, explain:

_____

_____

Has the child experienced major changes/events during the past year? □ Yes □ No, if Yes, explain:

_____

Is the child presently seeing another counselor? □ Yes □ No, If Yes, Who? _____

Has the child had previous counseling or psychotherapy? □ Yes □ No If Yes, please share when and for what reason.

_____

_____

Behaviors/Symptoms Check behaviors/symptoms that occur more often than you would like:

□ Anger/aggression
□ Alcohol/drug use
□ Anti-social behavior
□ Anxiety
□ Avoidance
□ Chest pain
□ Critical of self/others
□ Cyber/internet use
□ Depression
□ Disorientation
□ Distractibility
□ Elevated mood
□ Fatigue
□ Gambling
□ Hallucinations
□ Heart Palpitations
□ High blood pressure
□ Hopelessness
□ Irritability
□ Judgment errors
□ Loneliness
□ Memory impairment
□ Mood shifts
□ Over/under eating
□ Panic Attacks
□ Phobias/Fears
□ Recurring thoughts
□ Sexual thoughts/acts
□ Seeing things/visons
□ Sick often
□ Sleep problems
□ Suicidal thought
□ Thoughts disorganized
□ Withdrawing
□ Worrying

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Education

Current grade: _____ Home schooled? ____ YES ___ NO

Special Services: ____ 504 ____ GT ____ Special Education. Does the child have an IEP? ___ YES ___ NO

Does the child visit with the school counselor or participate in social skills groups or other groups?

___YES ___ No

Family Information

*Note: Please include all people living in the home. You may use the back of the page if needed.

			Living?		Living with you?	
Relationship	**Name**	**Age**	**Yes**	**No**	**Yes**	**No**
Mother						
Father						
Spouse/Partner						
Siblings						

Please list significant others, siblings, grandparents, half-relatives, etc.						

Child's Development from Birth

Delivery Term: ____ Full term ____ Born early at ____weeks gestation. Time in NICU:_____

Age at which child began walking: _____

Age at which child began talking: _____

Has the child receive any early interventions: ____No ____Yes Which ones? __Speech ___OT ___PT

Has the child receive any diagnosis prior to today's appointment? _____

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Family of Origin (the family the client was born into and/or raised with)

Child's Parents:

□ Married/Together

□ Divorced/Separated

□ Mother remarried; Number of times: _____

□ Father remarried; Number of times: _____

Please not the age of the child at time of divorce if applicable: _____

□ Special circumstance (e.g. raised by person other than parents)

Please describe:_____

Development

Are there unusual or traumatic circumstances that affected the child's development? □ Yes □ No
If Yes, describe: _____
Is there a history of abuse? □ Yes □ No
If Yes, which type(s)? □ Sexual □ Emotional □ Physical □ Verbal
If Yes, the abuse was as a: □ Victim □ Perpetrator
Other childhood issues: □ Neglect □ Inadequate nutrition □ Other: _____

Cultural/Ethnic

To which cultural or ethnic group do you belong? _____
Is your child experiencing problems due to cultural or ethnic issues? □ Yes □ No
If Yes, please describe: _____
Other cultural/ethnic information you want to share:
_____

Religious/Spiritual

How important to your child are religion/spirituality? □ Not at all □ A little □ Moderately □ Very
Do you and your child belong to a religious or spiritual group? □ Yes □ No If Yes, Which one do you belong to? _____
Do your religious or spiritual beliefs help you and your child cope in life? □ Yes □ No If Yes, explain:
_____

Would you like your religious or spiritual beliefs incorporated into counseling? □ Yes □ No
If yes, describe:
_____

Support Network

My child's network of support and encouragement includes the following: (check all that apply)

□ Myself	□ Classmates	□Extra-curricular group	
□ Neighbors	□ Family of origin	□ Extended Family	□ Friends
□ Religious/Spiritual Group	□ Social Networks	□ Other: _____	

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Medical/Physical Health

Does the child have (or have a history of) medical problems in the following areas:

□ Neurological
□ Chronic Pain
□ Ear/Nose/Throat
□ Cardiology
□ Abdominal pain or difficulties with elimination
□ Musculoskeletal
□ Skin
□ Respiratory
□ Other: _____

Explanation if necessary:

_____

_____

Medical/Physical Health (*continued*)

List any recent health or physical changes for the child:

_____

_____

Has the child ever been hospitalized? □ Yes □ No If so, for what? (Please list only those that occurred in the last 3 years or are related to the child's current issue or problem.)

_____

_____

Substance Use Questions

Does the child drink alcohol? □ Yes □ No If Yes, how much?
_____

Does the child use illegal drugs? □ Yes □ No If Yes, what/how much?

_____

Describe when and where the child typically use substances:

_____

Describe how the child's use has affected your family and/or friends.
N/A_____

Explanation:_____

_____

Reasons for use:
□ Addiction
□ Escape
□ Self- medication
□ Socialization
□ Taste
□ Other: _____

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Please read, initial, sign and date to complete the Client History Intake Packet.

Thank you for taking time to complete the Client History Intake Packet for Minors. While it is detailed and lengthy, please know it is necessary to have as much information as possible to get the best picture of your child's current circumstances so that an effective treatment plan can be put in place. As mentioned earlier, if there appears to be a mismatch in your child's needs and our services, we will be happy to assist you in seeking a professional who can support you and your child's therapeutic goals.

_____ Please initial here confirming that the information in this packet is true and accurate to the best of your knowledge and you understand we may or may not begin working together based on the information found herein.

_____ _____

Parent/ Guardian's Signature Today's Date