Resilience Counseling Minor Client - Clinical Intake Form

Please fill out this form to the best of your ability. Please answer all questions as honestly and briefly as possible. We will have time to discuss important issues more in depth in your initial appointment and throughout the counseling relationship. It is important for your counselor to know the honest answers so that we are able to address your concerns safely and helpfully. All of your answers will be confidential. If the question is not applicable to you, please write N/A. Guardians and Parents, please have your child answer these questions with you if possible. Please tell your counselor if you need extra assistance in completing this intake form.

* Required

1. **Today's Date** *

   Example: December 15, 2012

2. **Client's Name** *

Parent/Guardian's Personal Information

3. **Parent/Guardian's Name(s)** *

4. **Parent/Guardian's Social Security Number(s)** *

5. **Parent/Guardian's Driver's License or State ID number(s) and state issued?** *

6. **Are you able to self pay?** *

   Mark only one oval.

   - Yes
   - No

7. **How did you hear about this counseling center?** *

8. **If you would like me to begin the process of becoming a mental health provider with your insurance provider, please state your insurance company's name.** *

9. **What is your ethnicity, city and state of your birth. If you were not born in the United States, in what country were you born?** *

10. **Parent/Guardian's Gender(s)** *

11. **Date(s) of Birth** *

Example: December 15, 2012

12. **What is your age(s)?** *

13. **What is your education level?** *

Mark only one oval.

- ◯ Didn't finish highschool
- ◯ Highschool or GED
- ◯ Some college
- ◯ Undergraduate degree
- ◯ Graduate and Post Graduate

14. **Current Home Address (Where do you live?)** *

15. **What is your email?** *

16. **May your child's counselor email you to leave a message?** *
Mark only one oval.

- ◯ Yes
- ◯ No

17. **Cell Phone Number (with area code)** *

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18. **May your child's counselor leave a voicemail or message on your cell phone?** *
Mark only one oval.

- ◯ Yes
- ◯ No

19. **Home Phone Number (with area code)** *

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20. **May your child's counselor leave a message at your home number?** *
Mark only one oval.

- ◯ Yes
- ◯ No

21. **Work Phone Number (with area code)** *

_____

22. **May your child's counselor leave a message at your work number?** *
Mark only one oval.

- ◯ Yes
- ◯ No

23. **What is the best way to contact you?** *
Check all that apply.

- ☐ Cell phone
- ☐ Email
- ☐ Home phone
- ☐ Work phone

24. **Please list two emergency contact persons in case of an emergency? (Name, Relationship, Phone number, email)** *

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25. **Who is your child's Primary Care Physician? (Clinic, Name and Phone number) How long have you been a patient?** *

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26. **Who is your child's psychiatrist? (Clinic, Name and Phone number) How long have you been a patient?** *

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27. **Are you active in any community or social groups?** *

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28. **Are you currently religious or spiritual? If yes, please describe your personal beliefs and/or affiliation.** *

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29. **What is your current military status** *

Mark only one oval.

- ◯ No Military Service
- ◯ Active Duty
- ◯ Active Reserve
- ◯ Inactive Reserve
- ◯ Combat Veteran
- ◯ Veteran

30. **What is your current relationship status?** *

Check all that apply.

- ☐ Married
- ☐ Partnered
- ☐ Single
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

31. **How satisfied are you with your current relationship status?** *

Mark only one oval.

	1	2	3	4	5	
Not Satisfied	◯	◯	◯	◯	◯	Very Satisfied

32. **Have you ever been convicted of a crime? If yes, please list the conviction(s) and when you were convicted? (Please include DWI or DUI if applicable)** *

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33. **Do you have any disabilities? If yes, please describe.** *

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34. **Who all lives in the home: name, age, & relationship to you.** *

35. **What is your current employment status?** *
Check all that apply.

- [ ] Full time employed
- [ ] Part time employed
- [ ] Self Employed
- [ ] Unemployed
- [ ] Retired
- [ ] Disabled from being employed
- [ ] Full-Time Student
- [ ] Part-Time Student

36. **Are you satisfied with your current employment status?** *
Mark only one oval.

	1	2	3	4	5	
Not Satisfied	◯	◯	◯	◯	◯	Very Satisfied

37. **If employed or a student, where are you employed and/or where do you attend school? (N/A if not applicable)** *

38. **Currently, what problems or concerns would you like your child's counselor to address with your child?** *

Check all that apply.

- [ ] Personal Mental Health Concerns
- [ ] Family Concerns
- [ ] Intimate Relationship Concerns
- [ ] Financial Concerns
- [ ] Career/School Concerns
- [ ] Behavioral Concerns
- [ ] Medical or Health Concerns
- [ ] Legal Concerns
- [ ] Parenting Concerns
- [ ] Addiction Concerns
- [ ] Interpersonal Concerns
- [ ] Abuse/Violence Concerns
- [ ] Grief/Loss Death
- [ ] Other

39. **If you checked other, please describe.** *

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40. **How difficult has it been for you to deal with these concerns?** *

Mark only one oval.

	1	2	3	4	5	
Not Difficult	◯	◯	◯	◯	◯	Extremely Difficult

Client Information (Client fills out if possible)

41. **What are you struggling with?**

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42. **How do you identify with your gender and/or sexuality?**

43. **How do you identify culturally and/or ethnically?** *

44. **What are your personal interests or hobbies?** *

45. **What grade are you in school?** *
Mark only one oval.

- ◯ Jr. High
- ◯ Freshman
- ◯ Sophomore
- ◯ Junior
- ◯ Senior

46. **How do you get along with others at school?** *
Mark only one oval.

	1	2	3	4	5	
In general I get along well with most people	◯	◯	◯	◯	◯	I keep to myself or I get mad alot

47. **How are you doing in school academically?** *
Mark only one oval.

	1	2	3	4	5	
I feel pretty successful	◯	◯	◯	◯	◯	I am failing and I do not like school

48. **Who were you raised with?** *

49. **Are your parents/guardians: single, married, divorced, and/or remarried?** *

50. **How difficult is it for you to deal with your family's issues?**
Mark only one oval.

	1	2	3	4	5	
Not Difficult	◯	◯	◯	◯	◯	Extremely Difficult

51. **What are the relationships like with your parents/guardians, siblings and/or other persons in the home?** *

52. **How happy do you feel most days?** *
Mark only one oval.

	1	2	3	4	5	
Very Unhappy	◯	◯	◯	◯	◯	Very Happy

53. **Who are the most influential persons for you?** *

54. **Did/do you have any supportive persons in your life? If yes, who?** *

55. **Have you ever experienced any painful losses of relationships or breakups or moves? (If yes, please describe what relationship ended, how long it lasted, and how and when it ended.)** *

Health, Stressor, and Trauma History

Client may need help from a parent or guardian to fill this part out.

56. **Has anyone in your family had a mental illness, mood/behavioral problem or addiction problem? Please list who and what problems briefly, even if that person was never diagnosed or didn't receive any treatment or support that you were aware of.** *

57. **Have you ever received any type of counseling, mental health or psychiatric services? If yes, please list where, clinician/provider name, and when you received those services.** *

58. **Have you ever been hospitalized for mental health problems or behaviors? If yes, what facilities and when were you hospitalized?** *

59. **If you have received mental health services in the past, what were your previous diagnoses or what issues were you working on?** *

60. **Are you currently taking any medications for any medical or health conditions? If yes, please list all current medications and dosage.** *

61. **Have you ever taken or are you currently taking any mental health medications? If yes, please list all of those medications including: dosage and whether they are current or past.** *

62. **Have you ever committed an act of violence or abuse on someone else? If yes, please describe: type of violence or abuse, who was hurt or abused and when it happened.** *

63. **Have you ever harmed pets or animals outside of hunting?** *

Mark only one oval.

- Yes
- No

64. **Do you own or have easy access to firearms?** *

Mark only one oval.

- Yes
- No

65. **Have you ever experienced physical abuse, harassment, bullying or assault? If yes, when and by who?** *

66. **Have you ever experienced sexual abuse, rape, or sexual assault? If yes, when and by who?** *

67. **Have you ever experienced a traumatic injury or been diagnosed with a life changing illness? If yes, please briefly describe the injury or illness and when this happened.** *

68. **Have you ever witnessed or experienced a traumatic event, accident or incident that sticks with you or that you remember very vividly? If yes, please briefly describe.** *

69. **Has anyone important to you died? Who, when and how did they die?** *

70. **Has anyone in your friend or family circles ever killed themselves? If yes, please state the person's name and your relationship with the person?** *

71. **Have you ever experienced thoughts of killing yourself or wishing you were dead? If yes, please state if this was in the past and when or if you are currently experiencing these thoughts?** *

72. **Have you ever hurt yourself intentionally? (Examples: cutting yourself, burning yourself, hitting yourself, pulling out hair on your body, etc.) If yes, please describe.** *

73. **Have you ever told anyone that you were going to or should kill yourself?** *

Mark only one oval.

- Yes
- No

74. **Have you ever attempted to kill yourself? If yes, please state when.** *

75. **Are you currently planning to kill yourself?** *

Mark only one oval.

- Yes
- No

76. **Have you ever experienced thoughts of killing anyone else? If yes, please list who it is or was that you want(ed) to kill and when you have had or if you are currently having these thoughts?** *

77. **Are you currently planning to kill someone? If yes, who and when?** *

78. **Have you ever experienced hallucinations or seen, heard, smelled, or felt things that others could not see, hear, smell or feel? If yes, please describe.** *

79. **Have you ever behaved in ways that seem very abnormal for you and your usual style of life? If yes, please describe.** *

80. **Do you ever find yourself going on spending sprees when you do not have the funds to cover such spending?** *

Mark only one oval.

- Yes
- No

81. **Have you ever gone periods of time where you needed little to no sleep and still felt energized without caffeine or stimulant use? If yes, please describe when this has happened to you.** *

82. **Do you ever feel like ideas are racing through or around your mind at a very rapid speed?** *
Mark only one oval.

- Yes
- No

83. **Have you ever noticed that there are times that you uncontrollably speak in a pressured and rapid manner? Almost as if you can't get the words out fast enough?** *
Mark only one oval.

- Yes
- No

84. **Do you find that your mood fluctuates quickly and strongly on a regular basis?** *
Mark only one oval.

- Yes
- No

85. **Have you noticed or has someone else ever commented that you may have an addiction problem? If yes, please describe the addiction and/or substance(s) used.** *

86. **Have you ever blacked out from taking pills or drinking alcohol?** *
Mark only one oval.

- Yes
- No

87. **How much caffeine would you say you consume, check all that apply? (coffee, hot tea, sweet tea, soda, etc.)** *
Check all that apply.

- [ ] None
- [ ] Daily
- [ ] Not every day but frequently
- [ ] 1-3 cups per day
- [ ] 4 + cups per day

88. **Have you ever used any of the substances listed below? Please check all that apply to you.** *
Check all that apply.

- [ ] Nicotine
- [ ] Alcohol
- [ ] Marijuana
- [ ] Stimulants (Adderall, Cocaine, Meth, Crack, etc.)
- [ ] Opiods (Hydrocodone, Oxycontin, Heroin, etc.)
- [ ] Benzodiazapines (Xanax, Valium, Klonopin, Ativan)
- [ ] Hallucinogens (LSD, Mushrooms, MDMA, Peyote)
- [ ] Other

89. **Have you ever felt uncontrollably angry towards yourself or others; or do you feel angry almost all the time?** *
Mark only one oval.

- ◯ Yes
- ◯ No

90. **Do you often feel like you can't do anything right?** *
Mark only one oval.

- ◯ Yes
- ◯ No

91. **Do you ever feel uncomfortably isolated or alone? (Not peaceful solitude)** *
Mark only one oval.

- ◯ Yes
- ◯ No

92. **Have you ever felt worthless, helpless, and unlovable? If yes, when did you feel this way and how long did it last?** *

93. **Have you ever felt like you go through periods of time when you sleep too much and still don't feel rested?** *

Mark only one oval.

- Yes
- No

94. **Have you gained or lost more than 20 pounds without medical reason, your trying or without noticing in the past 3 months?** *

Check all that apply.

- Yes
- No
- My weight has always fluctuated up and down.
- Lost 20 pounds
- Gained 20 pounds

95. **Have you ever felt very tearful or sad for no obvious reason?** *

Mark only one oval.

- Yes
- No

96. **When you feel sad or down, how long does this feeling last?** *

Check all that apply.

- Minutes
- Hours
- Days
- Months
- Years
- It seems like I have always felt this way.

97. **Do you exercise excessively?** *

Mark only one oval.

- Yes
- No

98. **Do you restrict your diet without medical or health professional advisement?** *
Mark only one oval.

- Yes
- No

99. **Do you binge and over eat to extremes?** *
Mark only one oval.

- Yes
- No

100. **Do you ever intentionally throw up after eating?** *
Mark only one oval.

- Yes
- No

101. **Do you feel upset or stressed when plans or circumstances change or situations or persons behave in ways that are out of your control?** *
Mark only one oval.

- Yes
- No

102. **Do you often find yourself feeling stressed in social situations?** *
Mark only one oval.

- Yes
- No

103. **Do you find yourself feeling highly stressed in certain situations? If yes, please describe when this happens.** *

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104. **Do you ever feel like life pressures are too overwhelming and too much for you to handle?** *
Mark only one oval.

- Yes
- No

105. **Do you have any paralyzing fears or phobias that disrupt your life or relationships? If yes, please describe.** *

106. **How many hours do you typically sleep per day?** *

107. **Do you have trouble sleeping? Please check all that apply to you over the last 6 months.** *
Check all that apply.

- [ ] No trouble with sleep
- [ ] Trouble falling asleep (takes more than 30min)
- [ ] Trouble staying asleep (wakes more than once per night)
- [ ] Nightmares

108. **Is there anything else that you can think of that is important for your counselor to know?**

Informed Consent for Counseling, Confidentiality and Financial Disclosure

Confidentiality:

- Your confidentiality is carefully guarded by your counselor and protected by Arkansas law under Privileged Information and professional ethical codes or practice as defined by the American Counseling Association (ACA) and the Arkansas Board of Examiners in Counseling. No information about your appointments or sessions will be released without your specific written authorization and consent. Confidentiality is legally limited. Those limitations include: if it becomes apparent in your counselor's professional opinion that you may do serious and foreseeable harm to yourself or to others, if information is subpoenaed by a court of law and in the case of mandatory reporting of child or vulnerable adult abuse/neglect.
- All counselor clinical notes compiled during the counseling relationship are for the counselor's professional use only. You are welcome to review your records at any time, as counseling is a collaborative process.
- Minor client's legal guardians have a right to consult with your counselor and review clinical records. I ask that all parents and guardians agree to protect their child's privacy and consult in support of your child's therapeutic goals or to address safety concerns. Trust between client and counselor is necessary for a healthy therapeutic process and privacy is an important component of this.
- As I am only accepting self pay clients, no third party billing parties or insurance companies will have access to your counseling records.

Client Rights:

- Clients are entitled to professional, compassionate and respectful counseling services. The counselor will meet with you in a timely manner and for the agreed upon time frame.
- If your counselor needs to reschedule the counseling session, your counselor will make all efforts allowed by you to contact you for rescheduling at a time that works best for both of your schedules.
- If you are delayed or need to reschedule your session, please do so with as much notice as possible via email or phone call/message. If you are delayed, it may not be possible to give you the full scheduled time frame that day.
- Your initial appointment will be your intake interview and you and your counselor will go through your intake form to gather any important background information to be able to better address your concerns and goal setting. You and your counselor will determine what strategies are needed to best assist you in achieving your goals. Should your counselor determine that your concerns require resources or competencies beyond what your counselor can provide, you will be assisted with referrals and resources to appropriate sources.
- During the counseling process, you may encounter difficult memories or issues that you do not wish to discuss at that time. You are entitled to tell your counselor that you do not wish to discuss this information at this time and your counselor will respect your limits and boundaries.
- If for any you or your counselor decides to terminate the counseling relationship, you are entitled to a refund of any unused pre-paid counseling fees.

Client Responsibilities:

- Your active, open and honest participation in the counseling process is essential for positive progress to be made. Change is not easy and can sometimes be uncomfortable, and counseling is for people who wish to make positive change in their lives. You will work with your counselor as a partner. This will require you to provide your counselor with feedback regarding the services and discuss what goals you would like to accomplish and integrate in between sessions.
- Payment for services is due the day of service or before. You will be charged any collection fees on missed payments and checks that are found to be insufficiently funded.
- If you miss an appointment without notifying your counselor via email/phone message in advance of your scheduled appointment, you will be charged for the scheduled time. (In cases of emergency, you must proactively communicate and provide adequate documentation to be exempt from being charged for the missed appointment.)

If you have any questions about the above, please discuss them with your counselor.

109. **Client- I consent to counseling with Amy Muse, MS, LPC and have read, understand and agree to the above statement, " Informed Consent for Counseling, Confidentiality and Financial Disclosure".** *

Mark only one oval.

- ◯ Yes
- ◯ No

110. **Parent/Guardian I consent to my child participating in counseling with Amy Muse, MS, LPC and have read, understand and agree to the above statement, " Informed Consent for Counseling, Confidentiality and Financial Disclosure".** *

Mark only one oval.

- ◯ Yes
- ◯ No

You, your parent/guardian and your counselor will sign and date the form at your first scheduled counseling session. Please type your name in the field provided below.

111. **Client Signature & Date**

112. **Parent/Guardian Signature & Date**

113. **Counselor Signature & Date**