ANTIOCH COUNSELING CENTER

Child Intake Form **CONFIDENTIAL**

The following form, which will become part of your record, will help us get to know you more quickly. Please answer each question as completely and carefully as you can. You may use the back of any page for additional comments.

Name:_____Date of Birth_____Age____Sex____

Present Address:_____
Number *Street*

_____
City *County* *State* *Zip Code*

Phone:(_ _ _) __ __ __-__ __ __ __ e-mail_____ Social Security #:_____

Race:_____ Who Suggested You Come In?:_____

Presently Living With: Parent(s)____Grandparent(s)____Aunt(s)/Uncle(s)____ Other_____

Grade in School:_____What School:_____

Where:_____Number of Years at School:_____

Religious Affiliation:_____Church:_____

Are you a member? Yes____ No____ Active____ Inactive____

Should There be an Emergency, Who Should We Call? Name: _____

Address:_____ Phone:_____

FAMILY MEMBERS

Relationship	Name	Age	Last Completed Grade in School	Occupation if Out of School
Father				
Mother				
Grandparents				
Brother(s)				
Sister(s)				

Describe any recent sickness or illness you have had that required medicine or going to the doctor:_____

_____

Are you currently going to your doctor on a regular basis? Yes_____No_____

When did you last go to your doctor?_____

Are you currently taking any prescribed medicine? Yes_____ No_____ If yes, what is it and how much to you take:_____

_____

Have you been to a counselor before? Yes_____ No_____ If yes, when?_____

Who was it? Name:_____ Address:_____

_____

Briefly tell us why you are here today: _____

_____

_____

_____

_____

Have there been times when the problem got better or disappeared? Yes_____ No_____

If yes, when?_____

What do you think helped?_____

_____

_____

Were there times when the problem was especially bad? Yes_____ No_____

If yes, when?_____

What made it bad?_____

_____

_____

Are there other people who play a major role in causing your problems or in helping you cope with your problems? Yes_____ No_____

Explain briefly_____

_____

Is there anything else that you believe might be important for your counselor to know at this time?_____

_____

_____

_____

_____

Using the scale below, please choose a number that describes your concern about each of the issues listed. Please rate every item.

0	1	2	3	4	5	6	7	8	9	10
No Concern					Moderate Concern					Extreme Concern

_____ Mad, Angry

_____ Sad

_____ School

_____ Eating Problems

_____ Afraid

_____ Nervous, Jittery

_____ Money Problems

_____ Bullying, Problems with Classmates

_____ Physical Problems

_____ Problems with Other Children

_____ Problems with Siblings

_____ Problems with Parents

_____ Religious/Spiritual Concerns

_____ Can't Pay Attention

_____ Thoughts of Hurting Yourself

_____ Trouble Making Decisions

_____ Unhappy Most of the Time

_____ Use of Alcohol, Drugs

_____ Use of Alcohol by Family Member

_____ Use of Other Drugs by Family Member

_____ Parents' Work

_____ Worry

_____ Other (specify) _____

_____ _____

I have read the Antioch Counseling Center Informed Consent Form and voluntarily request counseling services at the Counseling Center in accord with terms described on the Informed Consent Form.

Signature _____ Date _____

For clients age 17 and under, the signature or his/her custodial parent or guardian is required.

Parent/Guardian _____ Date _____

PLEASE SUBMIT PAYMENT WITH THIS FORM PRIOR TO FIRST SESSION