Client Name: ____ Age: _________ Date: ___________

Aspects of Life
COUNSELING SERVICES

98-020 Kamehameha Hwy Unit 201
Aiea, Hawaii 96701
Office: 808 445-6777
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Child/Adolescent Intake Information

(to be completed by parent or legal guardian)

Please complete the following questionnaire. This information will be discussed more thoroughly in session and used to determine goals for treatment.

CURRENT REASON FOR SEEKING COUNSELING

Patient referred to counseling by? ____

Relationship to patient? __________________________________

Briefly describe the problem for which you wish your child/adolescent receive counseling?

____

____

____

What would you like to see happen as a result of counseling?

____

____

CLIENT INFORMATION

Client's Name: ____ Date of Birth: ___________________

Address: ____

Age: ________ Sex: ________ Grade: ________ School: ____________________________________

Contact Number: _____________________________ Can I leave a message at this number: ☐ Yes ☐ No

Can I send text to this number: ☐ Yes ☐ No

Parent or Legal Guardian (living with client): ____

Mother's Occupation: ______________________________ Employer: ______________________________

Cell Phone: ______________________________ Can I leave a message at this number: ☐ Yes ☐ No
Can I send text to this number: ☐ Yes ☐ No
Work Phone: ____________________________ Can I leave a message at this number: ☐ Yes ☐ No

Father's Occupation: ____________________________ Employer: ______________________________

Cell Phone: ______________________________ Can I leave a message at this number: ☐ Yes ☐ No
Can I send text to this number: ☐ Yes ☐ No
Work Phone: ____________________________ Can I leave a message at this number: ☐ Yes ☐ No

List Siblings (include biological, adopted, foster, step, etc.):

Name	Age	Type (bio, step, etc.)	Sex	Lives with Client
___________________________	_______	_________________	☐ M ☐ F	☐ Yes ☐ No
___________________________	_______	_________________	☐ M ☐ F	☐ Yes ☐ No
___________________________	_______	_________________	☐ M ☐ F	☐ Yes ☐ No
___________________________	_______	_________________	☐ M ☐ F	☐ Yes ☐ No

Is there any other person living in the household other than parent or siblings? If yes, please list their name(s) and their relationship to the client.

____

____

Relationship Status of Biological Parents (please circle): Never Married But Together / Married / Separated / Divorced
How Long Together? ________________

If parents are divorced or separated does non-custodial parent share joint custody? ☐ Yes ☐ No Explain:
____

SCHOOL

What Grade is Client Currently in? _________ Average Grades: _________ Any Grades Repeated? _________
Any Behavioral Issues at School? ☐ Yes ☐ No If yes please explain:

____

MENTAL AND PHYSICAL HISTORY OF CHILD/ADOLESCENT

Does the client have any history of counseling? ☐ Yes ☐ No
If so When: ____________________________________ With Whom: _______________________

Clinical Diagnosis: __________________________________ Issues Addressed?
____

____

BASIC HEALTH: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of last Physical: ______________

Primary Physician: ______________________________________ Phone: __________________

Is child/adolescent taking any medication at this time? ☐ Yes ☐ No

If yes, list medications: ____

Does the client have any history of suicidal thoughts/ideations, plans, or attempts? ☐ Yes ☐ No

If yes please explain: ____

____

Are there any physical, emotional, or mental conditions past or present that I should be aware of?

☐ Yes ☐ No If yes, Explain: ____

____

Has client ever been hospitalized? ☐ Yes ☐ No If yes, how long? _______________

Explain: ____

Please circle any of the following that presently concern you regarding the client:

Aggressive	Health Problems	Stomach Problems	Alcohol Abuse	Legal Matters
Self-Concept	Sexual Problems	Nightmares	Loneliness	Concentration
Bedwetting	Suicidal Thoughts	Anxious	Physical Abuse	Insomnia
Learning Issues	Divorce	Temper	Depression	Sexual Abuse
Lack of Friends	Memory	Drug Use	School	Unhappiness
Fears	Self-control	Sadness	Other: __________________	

Now put a ✓ by the items that are the MOST concerning at this time.

____ ________________________
PRINT NAME OF PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT — RELATIONSHIP TO PATIENT

____ ________________________
SIGNATURE OF PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT — DATE

____ ________________________
PRINT NAME OF PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT — RELATIONSHIP TO PATIENT

____ ________________________
SIGNATURE OF PARENT/GUARDIAN OR PERSONAL REPRESENTATIVE OF PATIENT — DATE