Clinical Counseling Services of Cincinnati
4055 Executive Park Drive, Suite 210
Cincinnati, OH 45241
513-469-6226

Today's Date_____ **Client Intake Form – MINOR**

Client Name_____ DOB_____ Phone_____

Address_____ City_____ State_____ Zip_____

Identified Ethnicity ☐African American ☐Asian ☐Hispanic ☐Multiracial ☐Pacific Islander ☐White

Identified Gender: ☐Female ☐Male ☐Transgender ☐Other ☐Prefer Not to Answer

School _____ Grade _____

Mother's Name_____ DOB_____ Phone_____

Mother's Address _____ email_____

Father's Name_____ DOB_____ Phone_____

Father's Address _____ email_____

Parents Married ☐No ☐Yes

Step Mother's Name _____ DOB_____ Phone_____

Step Father's Name _____ DOB_____ Phone_____

Siblings Name(s) and DOB _____

Previous Counseling Treatment ☐No ☐ Yes Where_____ When_____

Please List All Current Medications, if applicable.

_____

Preferred Method of Communication ☐email ☐phone

Responsible Party Information

Insured's Name_____ DOB_____ ID#_____

Insurance Co._____ Phone _____

Employer_____ Phone _____

Did You Preauthorize this visit ☐ No ☐Yes Authorization #_____

Employment Assistance Program Name (EAP)_____

Phone_____

Referral Source_____

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Religious/spiritual Information

Do you consider your family to be religious? ☐No ☐Yes

If Yes, what Is your faith?_____

If No, do you consider your family to be spiritual? ☐No ☐Yes

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., siblings, parents, uncle, etc.)

☐Depression
☐Bipolar Disorder
☐Anxiety Disorders
☐Panic Attacks
☐Schizophrenia
☐Alcohol/Substance Abuse
☐Eating Disorders
☐Learning Disabilities
☐Trauma History
☐Suicide Attempt(s)

Health and Social Information

1. How is your child's physical health at present?
   ☐Poor ☐Unsatisfactory ☐Satisfactory ☐Good ☐Very Good
2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, diabetes, etc.)_____
   _____
3. Does your child have any allergies? ☐ No ☐Yes Please explain_____
   _____
4. How often does your child get physical activity?_____
5. Does your child smoke cigarettes? ☐No ☐Yes How much?_____
6. Does your child drink caffeinated beverages? ☐No ☐ Yes How much?_____
7. Does your child drink alcohol? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never ☐N/A
   Amount consumed? _____

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8. Does your child engage in recreational drug use?

   ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never ☐N/A

   Amount consumed? _____

9. Has your child previously been treated for substance abuse? ☐No ☐Yes ☐N/A
10. What is your child's sexual orientation?

    ☐Heterosexual ☐Homosexual ☐Bisexual ☐Pansexual ☐Queer ☐Questioning

    ☐Other ☐Prefer not to answer

11. In the last year, has your child experienced any significant life changes or stressors? ☐No ☐Yes

    If yes, what were they:_____

    _____

12. Has your child ever been physically or sexually abused? ☐No ☐Yes

Has your child ever experienced any of the following (check all that apply)?

☐Extreme depressed mood
☐Mood swings
☐Rapid speech
☐Extreme anxiety
☐Panic attacks
☐Phobias
☐Sleep disturbances
☐Hallucinations
☐Unexplained losses of time
☐Homicidal thoughts
☐Unexplained memory lapses
☐Alcohol/Substance abuse
☐Frequent body complaints
☐Eating disorder
☐Body image problems
☐Repetitive thoughts (e.g., Obsessions)
☐Repetitive behaviors
(e.g., frequent checking hand-washing)
☐Suicide attempt

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OTHER INFORMATION

What do you consider to be your child's strengths?

_____

What is your biggest concern regarding your child?

_____

What changes would you like to see in the therapy process?

_____

Any other information you would like me to know about your child?

_____