New Life Counseling Center
14758 West Main Street
Cut Off, LA 70345
(985) 632-7797

Child / Adolescent General Intake

Personal Information

Client Name:_____ Date of Birth:_____ Age: _____

Address:_____ City:_____ State: _____ Zip _____

Phone Number (home)_____ (cell or parent's cell)_____

Grade in School: _____ School Name:_____

Family Information

Parent's Marital Situation: check all that apply

( ) parents married to each other ( ) separated ( ) divorced ( ) mom remarried ( ) dad remarried

How would you describe your family? _____

_____

_____

Current Living Arrangement (Who lives with you?)

Name	*Relationship to you (ex. step sister, dad)*	*3 words to describe your relationship with this family member*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Mother's Name:_____ Phone Number:_____

Mother's Occupation:_____ Mother's Age: _____

Father's Name: _____ Phone Number:_____

Father's Occupation: _____ Father's Age _____

General Information

What do your parents hope you will get out of coming to New Life?_____

_____

What would you like to see change in your life?_____

_____

What are the three most stressful things in your life right now?

1._____

2._____

3._____

Have you ever been seen by a counselor before? ( ) yes ( ) no

If yes, when? _____ by whom? _____ why?_____

What characteristics do you think are important in a counselor? _____

_____

Are you currently taking any medications? ( ) yes ( ) no

If yes, please list all medications & dosages:_____

Do you consider yourself to be a religious person? ( ) yes ( ) no

If yes, what religious faith do you practice? _____

How much of an impact do your religious beliefs have on your thoughts & behaviors?
( ) none ( ) very little ( ) some ( ) very much

Do you have spiritual concerns you would like to discuss in counseling? ( ) yes ( ) no

If yes, what are these concerns?_____

What do you plan to do after high school?_____

Have you ever been in trouble with the law? ( ) Yes ( ) No

If yes, please explain _____

What is your best subject / course in school?_____worst? _____

What is your favorite thing about yourself? _____

What is your least favorite thing about yourself?_____

Interpersonal Relationships:

Who are the three most significant / important people in your life right now?

Name	Type of relationship
_____	_____
_____	_____
_____	_____

Do you find it easy to make and keep friends? ( ) yes ( ) no

Have you ever been excessively picked on or made fun of? ( ) yes ( ) no

Do your parents approve of the friends you have? ( ) yes ( ) no

If no, why not? _____

How do you get along with your parents? _____

Crisis Information

Do you have any current suicidal thoughts, feelings, or actions? ( ) yes ( ) no

If yes, please explain:_____

Do you have any current thoughts of harming someone else? ( ) yes ( ) no

If yes, please explain:_____

Have you had any past problems, hospitalizations or jailing for suicidal or assault behaviors?

( ) yes ( ) no If yes, explain:_____

What do you do when you are really angry?_____

_____

Have you ever been physically, emotionally, verbally, or sexually abused? ( ) yes ( ) no

If yes, please briefly explain_____

Have you ever been accused of physically, emotionally, verbally, or sexually abusing someone else?

( ) yes ( ) no If yes, please explain _____

_____

Please check all of the following that apply to you:

- Irritable, Easily Frustrated
- Thoughts of Death
- Athletic
- Cry Easily
- Sad, Unhappy
- Difficulty Concentrating
- Teased, picked on, victimized, bullied
- Truant, school avoiding
- Intelligent
- Nightmares
- Difficulty Sleeping
- Nervous / Anxious
- Frequent Mood Changes
- Friendly
- Restless
- Artistic
- Prejudiced
- Recent Move
- New School
- Stubborn
- Good Leader
- Run Away
- Happy
- Self- harming Behaviors (biting, cutting, scratching, or burning self)
- Suicide Attempt
- Swearing, Bad Language
- Uncoordinated, accident-prone
- Get Along With Parents
- Lots of Friends
- Get Along With Siblings
- Fearful, Afraid
- Use Drugs
- Alcohol Use
- Procrastinate
- Feelings Easily Hurt
- Cruel to Animals
- Complainer

- Cheat on Tests / Assignments
- Bully, Intimidate Others, Tease Others
- Talk Back to Adults
- Need to Lose Weight
- Fire Setting ○

Independent ○

Exercise

- Disrupt Family Activities
- Like to Be Alone
- Creative
- Shy
- Angry
- Difficulty Making Decisions
- Depressed
- Hard to Control Myself ○

Overwhelmed by Life ○ Kind

- Low Self-Esteem
- Concerned About My Friends
- Eating Disorder
- Failure
- Dependent, Immature
- Often Feel Sick ○

Failure in School ○

Musical

- Recent Death of Friend / Family
- Enjoy Risky Behaviors
- Sexually Active
- Waste Time
- Feelings Easily Hurt
- Worry A Lot
- Easily Distracted
- I Don’t Like My Family
- My Parent’s Don’t Understand Me
- Disorganized
- Difficulty Learning
- Steal Things
- Good at Manipulating Others

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Consent to use and disclose your health information

This form is an agreement between you, _____ and me / us _____. When we use the word "you" below, it can mean you, your child, a relative, or other person if you have written his or her name here _____.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information here to decide on what treatment is best for you and to provide any treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sing this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy by calling us at 985-632-7797, or from our privacy officer.

If you are concerned about some of your information, you have the right to ask us to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to do as you asked.

After you have signed this consent, you have the right *to* revoke it (by writing a letter *to* our Privacy Officer telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name of client or personal representative Relationship to the client

_____
Description of personal representative's authority

_____
Signature of authorized representative of this office or practice

☐ Copy given to the client/parent/personal representative.

New Life
Counseling Center

CONSENT TO TREAT MINOR CHILDREN

I, **_____,** parent or legal guardian of **_____,** do hereby consent to treatment or counseling, with and/or without me present in the same session. I/We understand that we are the holder of confidential privilege – the right to withhold disclosure of private counseling information about my child. However, in the interest of developing a trust relationship between the counselor and my/our children, I/we give the counselor permission to reveal or reserve information that is in his/her clinical judgment necessary to commit to best practices in regard to therapeutic progress and protection of my/our child(ren). The only exception to this discretion would be in the case of:

_____

_____.

Parent/Legal Guardian signature:_____ Date: _____

Parent/Legal Guardian signature:_____ Date: _____

Cases in which both Mother and Father are not available for consent must be documented in detail.

Counselor/Witness signature: _____ Date: _____