Minor Intake Form

Welcome to **Fairbanks Biofeedback & Counseling**. I look forward to providing you with excellent and efficient counseling services. Please take a few minutes to print and complete this form. The information helps me to understand your situation and find potential solutions to get you and your child back on track. Please note that this information is confidential and will not be released to anyone without your written permission.

General Information

Child's Name: _____

D.O.B.: _____ **Age:** _____ **School:** _____

Teacher: _____ **Grade:** _____

Briefly describe your goals for your child's therapy: _____

_____

_____

_____

_____

_____

How does your child do in school academically? _____

_____

_____

_____

How does your child do in school behaviorally? _____

_____

_____

_____

_____

Does your child have a learning or physical disability? *(circle)* No Yes Maybe

Specify: _____

_____

_____

_____

Has your child been in counseling before? With whom? What was helpful and/or not helpful with your previous counseling? _____

_____

_____

_____

_____

_____

Medical History

During pregnancy, did mother use: *(circle)* Cigarettes Alcohol Drugs

During pregnancy, did mother experience extreme stress? *(circle)* Yes No
Specify frequency, amounts, and duration: _____

_____

_____

List any birth complications: *(e.g. premature, jaundice, C-section, etc.)* _____

_____

_____

List any medical conditions or history: *(e.g. surgeries, broken bones, allergies, etc.)* _____

_____

_____

Does child use: *(circle)* Cigarettes Alcohol Drugs
Specify frequency, amounts, and duration: _____

_____

Primary Care Physician: _____

Current medications: *(include dosage and frequency)* _____

_____

_____

_____

Medication allergies: _____

_____

Other allergies: _____

_____

In the first two years of life, did your child experience: *(circle)*

Separation from mother	Out-of-home care	Disruption in bonding	Depression of mother
Abuse	Neglect	Chronic pain	Chronic illness

Specify: _____

_____

_____

Your child has reached developmental milestones: *(circle)* On-time Early Late

How many times has the child moved homes? _____

Please provide five adjectives that describe the following:

Mother: _____

_____

Father: _____

_____

Child: _____

_____

Parental Relationship: _____

_____

Family History

Biological Father: _____ **DOB:** _____

Biological Mother: _____ **DOB:** _____

Date: Married ___/___/___; Separated ___/___/___; Divorced ___/___/___

People in household, if different from above: _____

_____

_____

Does father work outside of the home? *(circle)* Yes No

Occupation: _____ Hours: _____

Does mother work outside of the home? *(circle)* Yes No

Occupation: _____ Hours: _____

If separated or divorced, visitation schedule: _____

Does either parent have legal issues? *(circle)* Yes No

Specify: _____

List any history of mental illness or addiction in immediate and extended family:

(e.g. depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.): _____

_____

Has your child witnessed domestic violence? *(circle)* Yes No

Specify: _____

_____

How is your child disciplined? _____

_____

_____

_____

Trauma History

Has your child been verbally abused? *(circle)* Yes No Suspected

Specify: _____

_____

Has your child been physically abused? *(circle)* Yes No Suspected

Specify: _____

_____

Has your child been sexually abused? *(circle)* Yes No Suspected

Specify: _____

_____

Other stressors or traumas? _____

_____

Circle symptoms your child displays:

Anger	Impaired conscience	Phobias
Anxiety	Isolation	Playing out violent themes
Acting out sexually	Lack of empathy	Playing out sexual themes
Bed wetting	Lack of motivation	Running away
Conduct problems	Lethargy	Shyness
Defiance	Low impulse control	Sleeplessness
Depression	Low self-esteem	Somatic symptoms
Disassociation	Lying	*(e.g. headaches,*
Drug or alcohol use	Nightmares	*stomachaches, etc.)*
Homicidal thoughts or actions	Obsessing	Stealing
Hyperactivity	Over/under eating	Tantrums
Hyper vigilance	Peer problems	Unusual sexual knowledge

Other symptoms: _____

_____

_____

_____

How does your child handle anger? _____

_____

_____

_____

_____

Has your child experienced any significant loss? If yes, explain: _____

_____

_____

_____

What do you view as your child's major strengths and positive traits? _____

_____

_____

_____

_____

What are your child's hobbies? _____

_____

_____

_____

_____

Briefly describe your child's relationship with his/her peers: _____

_____

_____

_____

_____

Please list any other information that you think may help me to understand your child and develop an action plan. _____

_____

_____

_____

_____

_____