Free Your Mind Therapy Services, LLC
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Child/Minor Intake Form

Parent Name(s): _____
Today's Date:_____
Child's Name: _____
Child's Date of Birth:_____
Age: _____ Gender: _____
Referred by: _____
Address: _____
City/State/Zip: _____
Email:_____
Telephone: Parent Cell _____ Parent Cell _____
Home _____
Would you prefer appointment reminders by: (circle one) Text Email None

Presenting Problem
Briefly describe the problem or concern that led you to seek professional services for your child:

How would you rate the intensity of this problem or concern?

Extremely Intense		Moderately Intense		Not Intense
5	4	3	2	1

Approximately how long has your child had the current problem or concern?

In what ways have you attempted to cope with this problem or concern?

Behavioral Excesses: What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits: What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets: What does your child do that you like? What does he/she do that other people like?

Treatment Goals

From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST, and how much must they change for you to be satisfied?

Family History

Names of the child's biological parents:

Mother:_____

Father:_____

Who has legal guardianship of your child?

_____

Who does your child currently live with?

NAME	AGE	RELATIONSHIP TO CHILD

If any, who are your child's siblings/step-siblings NOT living in the same household with your child?

NAME	AGE	RELATIONSHIP TO CHILD

Please describe any past counseling that your child has had.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol?

□ No

□ Yes, Please describe:

Education History

What school does your child attend?

_____

Current Grade:_____

Teacher's Name:_____

What does your child's teacher say about him/her?

Has your child ever repeated a grade? If so, which one(s)?

Has your child ever received special education services? If so, please list them.

Has your child experienced any of the following problems at school?

___ Behavioral Problems
___ Incomplete Homework
___ Lack of Friends
___ Poor Grades
___ Learning Disabilities

___ Poor Attendance
___ Fighting
___ Detention
___ Suspension/Expulsion
___ Gang Influence
___ Drugs/Alcohol

General Health Information

Has your child had a medical exam in the past year? □ Yes □ No (If Yes Provide date)

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other Information

Has your child ever experienced any type of abuse (physical, sexual, or verbal)? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else? If so, please describe the situation:

Has he/she ever purposely hurt himself or another? If so, please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If so, please explain:

Parent/Guardian Informed Consent for Treatment, Payment, and Privacy

I have been provided with Free Your Mind Therapy Services, LLC detailed Informed Consent and Privacy Practices. Sessions are approximately 50 minutes and payment is $73 per session, unless otherwise specified. All payments are due in full at the time services are rendered. Cash, checks, major credit cards, and HSA cards are accepted. A $3 discount will be applied to all payments made by cash or check.

I will make every effort to be on time for my appointments. If I am late for my appointment, I understand that time will be forfeited from my session. If I need to cancel or reschedule, I will do so at least 48 hours before my scheduled appointment. ***If I do not cancel within 48 hours or no show to my appointment, I understand that my credit card on file will be charged the full session fee ($73) at the time of the missed appointment.***

I acknowledge that, in compliance with HIPAA regulations, my records and communications are considered confidential and privileged information. This privilege may be waived if there is clear and immediate probability of physical harm to the client, to other individuals, or to society and the therapist must warn any potential victim, law enforcement, or other appropriate authorities.

Signature _____Date_____