Please save the completed form and email it to frontdesk@panamacitywellness.com

625 Jenks Avenue Panama City, Florida 32401 * Office 850-215-5657 * FrontDesk@PanamaCityWellness.Com

****This professional relationship does not begin until the Intake session where the forms are then reviewed, agreed upon, and the consent form is signed by the therapist and those involved. If this is an emergency prior to the initial session, please contact 911.**

CHILD INTAKE FORM (Up to Age 11)

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank, and we can discuss it when we meet. The Parent/Guardian fills out the first part of the packet and the child section can be filled out either by the parent or by the child based on their ability level.

Name: _____ Today's Date: _____ Form Filled out by: _____

Would like to be called: _____ Relationship to child of who filled out form: _____

E-Mail address: _____ Date of Birth: ____/_____/_____ Gender M__ F__ Race _____

Social Security Number: _____ Who referred you to this office? _____

Email Address: _____ Is Leaving Messages on personal numbers okay? _____

Address: _____ Home Phone (____) _____

_____ Parent/Guardian's Cell (____) _____

_____ Child's Cell Phone (____) _____

School: _____Grade: _____ Employer: _____

Hobbies/Clubs: _____ Phone #: _____

_____ GW Counselor: _____

Religious Beliefs: _____ Desired Counseling Mode: ___Ind ___Grp ___Fam

Emergency Contact: Name: _____Relationship_____

Address: _____ Phone (____) _____

INSURANCE INFORMATION

Insurance Co: _____ Policy #: _____

Are you the Child's policy holder? Yes or No Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ and Policy Holder's SSN_____

FAMILY INFORMATION

FAMILY HISTORY (Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Father's Name: _____Birth Date: _____ Age: _____ Phone Contact: _____
Ethnic Origin: _____ Total years of education completed: _____
Occupation: _____ Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____
Father's/Guardian's Address: _____
Father's/Guardian's e-mail Address: _____

Mother's Name: _____Birth Date: _____ Age: _____ Phone Contact: _____
Ethnic Origin: _____ Total years of education completed: _____
Occupation: _____ Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____
Mother's/Guardian's Address: _____
Mother's/Guardian's e-mail Address: _____

Any Other Active and Authorized Guardian's Name: _____ Phone Contact: _____
Relationship to youth_____ Address: _____
e-mail Address: _____

PARENT'S MARITAL STATUS

_Single _Married (legally) _Divorced _Cohabitating _Divorce in process _Separated _Widowed _Other_____
_____

Length of marriage/relationship: _____

If divorced, how old was your child at time of divorce? _____

If divorced, how much time does your child spend with each parent?

Mother_____%, Father _____%

Custody:

Who has legal custody of the child? ___ Parents___Mother___Father ___Grandparents___DCFS__Other: _____

Are there any custody considerations of which the counselor should be aware? _____

Who has decision making Authority of Behavioral Health? _____

Visitation: _____

Copy of Custody Arrangement has been provided to be on File: Yes _____ No_____

Is Child Adopted _____ If Yes, where and at what age? _____

If child is adopted, what does the child know about the adoption and/or Birth Family? _____

_____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship	Age	Sex	Type	Living with you?
	(Parent, Sibling, etc.)			(Bio, Step, etc.)	

1._____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

__Fighting
__Feeling distant
__Loss of fun
__Lack of honesty
__Medical Concerns
__Education problems
__Financial problems
__Death of a family member
__Inadequate health insurance
__Inadequate housing/feeling unsafe
__Disagreeing about relatives
__Disagreeing about friends
__Alcohol or Drug use
__Trauma
__Infidelity (couple)
__Divorce/separation
__Issues regarding remarriage
__Birth of a child
__Job changes or job dissatisfaction
__Other_____

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____

_____

Have you or anyone in your family been treated for issues relating to depression, anxiety, self-harm, suicide, or other mental health disorders? If so, please describe: _____

_____

_____

CHILD'S DEVELOPMENT

Were there any complications or health problems with the pregnancy or Birth of your child? Yes___ No___ If yes, describe:_____

_____

_____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes ___ No ___ Not sure_____
If yes, describe: _____
_____
_____

Did your child have any unusual behaviors or problems from 1 to current in their life? Yes ___ No ___ Not sure_____
If yes, describe: _____
_____

Has your child experienced emotional, physical, or sexual abuse? Yes ____ No ____ Not sure
If yes, describe: _____
_____
_____

CHEMICAL USE
Do you have any concerns of your son or daughter using alcohol or drugs? (Y/N) _

If yes, please explain your concern: _____
_____
_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter at present, or have had a significant effect upon you or your son or daughter in the past: _____
_____
_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter's choices using the internet or electronic communication such as amount of use period or the use up Facebook, Snapchat, Twitter, texting, etc? (Y/N) _____
If yes, please explain your concern: _____
_____
_____

SCHOOL HISTORY
Does your child like school? (Y/N) _____

Does your child attend regularly? (Y/N) _____

How are your child's grades? (circle one)

___(A's) ___(A's & B's) ___(B's) ___(B's & C's) ___(C's) ___(C's & D's) ___(D'S) ___(D's & F's) ___(F's)

Do you feel they are doing the best they can at school? (Y/N) _____

Is there anything else you would like me to know about their school experience:
_____
_____

YOUR CHILD'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____
_____

What personal qualities would you say your son or daughter has?

_____
_____

Who are some of the influential and supportive people, activities (e.g., walking) or beliefs (e.g., religion) in your son or daughter's life? (Please describe)

_____
_____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? Yes__ No__

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did your son or daughter go to counseling?

_____
_____

Does your son or daughter have a previous mental health diagnosis and if so by who and when given?

_____

What did you find most helpful in therapy?

_____
_____

What did you find least helpful in therapy?

_____
_____

Has your son or daughter used psychiatric services? Yes____ No____

If yes, who did they see? _____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Has your son or daughter ever been suicidal? Yes___ (current or past) No ___ ?

Has your son or daughter ever used self-harm Yes___ (current or past) No ___?

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N

If so, please describe: _____

If you have been given a previous diagnosis, what was it?

_____

Who was it by _____and when? _____

Current Reason For Seeking Counseling For Your Child

Briefly describe the problem for which your Child is seeking to have counseling.

_____
_____
_____
_____

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

_____
_____

What is most concerning right now?

_____
_____

Is there anything else you would like me to know: _____
_____
_____
_____
_____

FORM CONTINUES ON NEXT PAGE

CHILD SECTION

(If applicable to ask your child their view of themselves on this section or have them fill out this section please do so. This section will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question or they do not apply then you may leave it blank, and we can discuss it when we meet.

Please circle who answered this section: Child answered, Parents/Gaudian answered, or answered by Both.

PEER RELATIONS

How do you consider yourself socially? ___outgoing ____shy ____depends on the situation?
Are you happy with the number of friends you have? (Y/N) _____
Have you ever been bullied? (Y/N) _____
Are you or have you been dating (Y/N) _____ and if so with (Male, Female or other)?
Are you involved in any organized social activities (e.g. sports, scouts, music)? _____
_____
Does your parent (s) like your friends? _____ How would they describe the people you most hang out with?
_____
_____

Who is your best friend and what would I see you and your best friend most often doing together?
_____
_____

If your guardians were fussing at you, what would they be fussing about and how would this differ between each guardian? _____
_____
_____

PERSONAL STRENGTHS (If applicable to ask your child their view of themselves on this section or have them fill out this section please do so).

What activities do you enjoy and feel you are successful when you try?
_____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)
_____
_____

CHEMICAL USE

Have you ever used more than 1 chemical at the same time to get high? ___

Do you avoid family activities so you can use? _____

Do you have a group of friends who also use? _____

Do you use to improve your emotions such as when you feel sad or depressed?? _____

Please describe what history of drug or alcohol problems may exist in your family or close relationships?
_____
_____
_____

CURRENT PROBLEM IMPACT

(If applicable to ask your child their view of themselves on this section or have them fill out this section please do so).

On a scale of 1-10, how much does this problem that brought you in interfere with your everyday living?
1 = little.....10 = greatly _____ Are you or have you been suicidal? Yes___ (current or past) No ___
Have you ever used self-harm Yes___ (current or past) No ___?

What caused you to seek counseling at this time? _____

_____

_____

What thoughts, feelings, and behaviors are associated with your problem? _____

_____

_____

_____

How does the problem interfere with your everyday living? _____

_____

_____

_____

Do you have any physical stress related complaints? _____

When did this problem that brought you in first appear? _____

How often does the problem affect your life? _____

_____

_____

Do you notice any patterns (people, places, or events/before, during or after) that surround the problem? _____

_____

_____

What actions have you taken to deal with the problem? _____

_____

_____

What strengths do you have that have helped you deal with the problem? _____

_____

_____

Who is on your side that is or could be helpful with this struggle you are facing? _____

_____

What are the top three things you most want to see different regarding this issue from counseling?

_____

_____

_____

_____