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PAGE 2 SHOULD BE COMPLETED BY THE MINOR CLIENT. PARENTS SHOULD SUPERVISE COMPLETION OF THE REMAINDER OF THE DOCUMENTS. A SEPARATE CHECKLIST IS AVAILABLE FOR PARENT COMPLETION IN A DIFFERENT ACCOMPANYING DOCUMENT.

Intake Questionnaire - Minor

By answering this questionnaire completely and honestly you will assist me in gathering the information I need in order to help you. The information disclosed is considered *Confidential & Privileged* and will not be released to any other party without your express written consent.

TODAY'S DATE_____

FIRST NAME_____ LAST NAME_____

ADDRESS_____

CITY/STATE_____ ZIP CODE_____

SCHOOL ATTENDING_____

CURRENT GRADE_____ YOUR D/O/B:_____

YOUR EMAIL_____

MOTHER'S NAME_____ CELL_____

FATHER'S NAME_____ CELL_____

Personal & Medical Information

What is the name of your physician / pediatrician?_____

When is the last time you saw your doctor?_____

Are there any medical issues you are being treated for currently?_____

_____

Current medications:_____

Name of psychiatrist, if any:_____

THIS PAGE IS TO BE COMPLETED BY THE MINOR CLIENT

Place a check (√) by all which apply. Put two checks (√√) for more serious problems and three checks (√√√) for the ones you consider really severe:

_____depression
_____alcohol abuse
_____nightmares
_____feeling down, blue
_____money problems
_____worried about my sister/brother
_____drugs, drinking
_____medical problems
_____thoughts of hurting myself
_____haunted by my past
_____anger
_____seeing things
_____highly irritated
_____chemical dependency
_____overeating
_____inability to concentrate
_____cravings
_____smoking pot
_____sluggishness
_____feeling misunderstood
_____people are trying to frame me
_____problems at school/work
_____worried I might be pregnant
_____hard to pay attention
_____relationship problems
_____girl problems
_____boy problems
_____I need a job
_____problems with authority
_____obesity
_____migraine headaches
_____breathing problems
_____compulsive behaviors
_____germs & cleanliness
_____sexually transmitted disease
_____afraid of getting old
_____afraid I may be gay
_____parents getting on my nerves
_____mood swings
_____I have secrets
_____I feel misunderstood

_____anxiety
_____problems getting along with others
_____school problems
_____agitated
_____legal problems
_____stupid shit
_____difficulty making friends
_____worried about my parent(s)
_____worried about the future
_____stress
_____demons
_____I am in trouble again
_____panic attacks
_____gambling
_____eating too much & throwing up
_____short attention span
_____family member's sexual advances
_____can't stop thinking of something
_____deviant fantasies
_____problems relaxing
_____a family member is an addict
_____problems at home
_____sexual problems
_____I get frustrated easily
_____sexual dysfunction
_____violence all around me
_____feeling unloved
_____arguments with the ones I love
_____vomiting
_____chronic pain
_____being overweight
_____drugs
_____urges to steal
_____I'm afraid of somebody
_____nothing is ever perfect enough
_____death of a loved one
_____living with a control freak
_____family problems
_____no one to talk to
_____people are out to get me
_____a loved one is terminally ill

Insurance

Insured's Name: _____

Insured's Birthdate:_____ Insured's Employer_____

Insurance:_____ Group #_____

Policy or Subscriber #:_____

Verification Phone_____

Address to submit claims: _____

Release of Information

I, _____, the undersigned, authorize the Provider to release confidential information to the health insurance company necessary to process any claims associated with the services provided.

_____ _____
Authorized Signature *Date*
Signature of Parent / Legal Guardian

Assignment of Benefits

I, _____, the undersigned, authorize benefits from my insurance plan to be paid directly to the Provider. I understand that in the event my insurance carrier pays a benefit check directly to me, the patient, that I am responsible for paying my provider directly.

_____ _____
Authorized Signature *Date*
Signature of Parent / Legal Guardian