***Balance for Life***

**Personal Consultant & Life Coach Service**

**Rick McCraw, MS**

**Minor Intake Form**

**To assist in helping you today, please provide the following information.**

**Have your child help you fill out this form.**

**All responses are strictly confidential.**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s (Minor’s) Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age: \_\_\_\_\_\_\_ DOB:** \_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Street City State Zip Code

**Minor’s Sex:** □ male □ female □ transgendered

**Minor’s School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person Responsible for Minor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to person responsible for minor:** □ child □ step-child □ adopted □ foster-child □ other

**Person responsible for minor relationship status:** □ single □ married □ cohabiting □ separated □ divorced

□ widowed □ dating □ divorce in process

**How would you prefer to be contacted?**

Home phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone? □ yes □ no May we leave a message? □ yes □ no Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email for scheduling purposes only? □ yes □ no Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by:**

**Person to Contact in Emergency:** **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Education**

Grade Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Learning disabilities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information** How would you rate client’s health? □ poor □ fair □ good □ very good □ excellent

**Client’s Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication:**

Is client currently taking medication? □ yes □ no If yes, please list: (Use back of page if necessary)

Medication: Dosage: Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: Dosage: Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: Dosage: Prescribing Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list all members of your immediate household** (living with you)**:**

**Name Relationship Age**

1. ­­­­ / /
2. / /
3. / /
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. / /

**Current Family & Significant Relationships:**

**Problem areas:** □ parenting □ conflict □ abuse/violence □ communication □ marital □ divorce

□ parent/child □ separation □ death □ sexual abuse □ discord with siblings

**Signs & Symptoms:**

Please check all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_ anger | \_\_ anxiety | \_\_ lack of coping skills | \_\_ abuse-physical |
| \_\_ confusion | \_\_ sexual concerns | \_\_ aggression/violence | \_\_ abuse-sexual |
| \_\_ fear/phobias | \_\_ depression | \_\_ suicidal thoughts | \_\_ abuse-emotional |
| \_\_ easily distracted | \_\_ sleeping problems | \_\_ racing thoughts | \_\_ social activities |
| \_\_ emotional | \_\_ family conflict | \_\_ financial stress | \_\_ negative self-talk |
| \_\_ marital concerns | \_\_ career/work related | \_\_ poor/unclear self-image | \_\_ low self-esteem |
| \_\_ indecision | \_\_ troubling behaviors | \_\_ feeling unhappy or blue | \_\_ caregiving issues |
| \_\_ medical problems | \_\_ parenting problems | \_\_ guilt or shame | \_\_ feeling worthless |
| \_\_ problems in school | \_\_ racing thoughts | \_\_ fear of dying | \_\_ helplessness |
| \_\_ housing | \_\_ domestic violence | \_\_ flashbacks | \_\_ social isolation |
| \_\_ excessive gambling | \_\_ panic attacks | \_\_ lack of motivation | \_\_ feeling numb |
| \_\_ shyness | \_\_ phobias | \_\_ fears | \_\_ mood swings |
| \_\_ absenteeism at work | \_\_ nerves | \_\_ withdrawal from friends | \_\_ difficulty relaxing |
| \_\_ legal problems | \_\_ eating disorder/issues | \_\_ body aches/ pains | \_\_ tearful |
| \_\_ friends | \_\_ addictive behaviors | \_\_ sadness | \_\_ poor impulse control |
| \_\_ stress | \_\_ grief/loss | \_\_ no friends | \_\_ headaches |
| \_\_ tiredness | \_\_ memory | \_\_ ambition | \_\_ making decisions |
| \_\_ hopelessness | \_\_ feeling inferior | \_\_ concentration problems | \_\_ bowel troubles |
| \_\_ irritability/on edge | \_\_ self-control | \_\_ temper | \_\_ appetite/weight |

\_\_ decrease in social & leisure activities \_\_ feeling down in the dumps \_\_ loss of interest in friends

\_\_ alcohol/drug abuse/addiction \_\_ loss of satisfaction in life \_\_ loss of interest in work

\_\_ other

**Please check if there have been any recent** (2 months or less) **changes in the following:**

\_\_ Sleep patterns \_\_ Eating patterns \_\_ Behavior \_\_ Energy level \_\_ Mood swings \_\_ Physical activity level

\_\_ Weight \_\_ General disposition \_\_ Nervousness/tension \_\_ Sex drive

**Reason for Coming Today:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information will help you and your consultant begin to clarify your therapy goals:**

**Has client ever been treated by a psychiatrist?** □ yes □ no Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_

**Hospitalized for mental health or chemical dependency treatment?** □ yes □ no Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has anyone in the household been treated for a mental health diagnosis or chemical dependency?**  □ yes □ no

**Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list all that apply: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has client been to counseling before?** □ yes □ no **Was it helpful?** □ yes □ no

**Is client feeling suicidal now?** □ yes □ no **In the past?** □ yes □ no

**Has client ever attempted suicide?**  □ yes □ no **When?** \_\_\_\_\_\_\_\_\_

**Goals for Change:**

**What are your goals for change? What would you like to accomplish?**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Form completed by** (minor)**:**   **Date:** \_\_\_\_\_\_\_\_\_\_\_

**And** (Parent signature)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Thank you for taking the time to provide this information.**

**CREDIT CARD INFORMATION**

**REQUIRED FOR BOTH TELEHEALTH**

**AND**

**FACE-TO-FACE COUNSELING.**

**AUTHORIZATION**: By signing this **CREDIT CARD FORM**, you authorize me to charge the following credit/debit card for all fees not paid by cash or check.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name on Card Card Type Credit Card # Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address associated with card including street, city, and zip code Exp. Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date