Monika W. Yen, LCSW
Licensed Clinical Social Worker
License # 28779

32242 Paseo Adelanto Suite D-3
San Juan Capistrano, CA 92675
949-903-4218
www.familywellnessoc.com

MINORS INTAKE FORM

Please note the information provided here is kept confidential.

Minors Name ____

Name of Parent/Guardian ____

Birthdate: ___________/_____________/________________ Gender

Please list siblings and ages ____

Do mom and dad live together? ____________________

If not, typical custody arrangements____

School child attends and grade ____

Address____
(Street and Number)

____
(City) (State) (Zip)

Home Phone: ________________________________ May we leave a message? Yes No

Cell/Other Phone: ____________________________ May we leave a message? Yes No

Cell/Other Parent Phone: _______________________ May we leave a message? Yes No

E-mail: ____ May we email you ? Yes No

*Please note that email communication is not considered confidential medium of communication.

Reason for Visit Today: ____

____

Referred by (if any) ____

Has your child previously received any type of mental health services (psychotherapy, psychiatric services, etc?

No Yes Previous therapist or practitioner ____

Is your child currently taking any prescription medication?

If yes, please list, ____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your child's current physical health? (please circle)

Poor Satisfactory Good Very Good

Please list any specific health problems currently experiencing or being treated:

____

2. How would you rate your child's sleep habits? (please circle)

Poor Satisfactory Good Very Good

3. How many times does your child exercise per week? _____________________________

4. What are his/her favorite activities, hobbies? ____

5. Please list any concerns about your child's eating patterns or appetite:

____

6. Is your child currently experiencing overwhelming sadness, grief or depression?

No Yes If yes, for how long?____

7. Is your child currently experiencing anxiety, panic attacks or any phobias?

No Yes If yes, when did this begin ?

____

8. Has your child experienced any major change recently? ____________________________

____

9. Does your child have difficulty in school, socially, behaviorally, or academically? Does your child have accommodations at school, 504 plan, IEP?

____

____

10. What are your major concerns about your child? ____________________________________

____

11. Has your child admitted to any alcohol intake or recreational drug use? Yes No

12. Has your child ever told you about suicidal or homicidal thoughts? Yes No

13. Has your child told you, or did you see, any evidence of self-harm or cutting? Yes No

14. Please list your child's strengths ____

____

FAMILY MENTAL HEALTH HISTORY:

In the section below, please identify any family history of mental health issues, and include the family member's relationship to the child.

	Please circle	List Family Member
Alcohol/Substance Abuse	yes no	
Anxiety	yes no	
Depression	yes no	
Domestic Violence or Abuse	yes no	
Eating Disorders	yes no	
Obsessive Compulsive Disorders	yes no	
Phobias	yes no	
Schizophrenia	yes no	
Bipolar Disorder	yes no	
Suicide Attempts	yes no	

Please list any other history here:

Please feel free to share any additional information below that you feel will be useful for the therapist to know about your child and/or family.