**Confidential Client Intake Form – Child 3-12 yrs.**
**To Be Completed By Parents**

## *General Information*

Child's Name: ______________________________________________ Date: ____________

Sex: ☐ M ☐ F Child's DOB: ______________Child's Age: _______SS#:_________________

Address: ___________________________City: ____________________State: ______Zip: ______

Home Phone: ___________________Cell #:_______________________Work #________________

Email Address:____________________________________________________________________

Child's School: ______________________________________________ Grade: ________________

Name of Parents: __________________________________________________________________

Parent's Employer: ________________________________________________________________

Occupation/Title:__________________________________________________________________

Name of Church/Pastor: ___________________________ Do you regularly attend a religious service: Y/N

Please list other children including step, adopted and foster:

| Name | Sex | Age/Year of death | Relationship to you | Describe him/her |
|---|---|---|---|---|
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## *Counseling History*

Has your child had any previous counseling, please list the name of the therapists and/or programs:

| Name of Therapist/Program | Issues Addressed | Dates in Treatment |
|---|---|---|
| | | |
| | | |

***Medical History***

List any physical illnesses or conditions over the last year that might be relevant to your child seeking counseling:

_______________________________________________________________________________

Please list all current medications you are taking (even if use is seldom or as needed):

| Name of Medication | Dosage | Reason for taking medication |
|---|---|---|
| | | |
| | | |

***Present Issues and Goals***

Please describe why you are bringing your child to counseling (issues, problems, symptoms, how long, etc.):

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Please place an "X" on the scale to indicate how distressing your child's problems are to him/her.

{---------------------------------------------------------------------------------------------------------------------------------------}
Very minimal distress                Moderate distress                Very extreme
distress

Is your child currently experiencing any suicidal thoughts? ☐Yes ☐No
Have your child experienced suicidal thoughts or attempted suicide in the past? ☐Yes ☐No
Is your child currently experiencing any violent or homicidal thoughts? ☐Yes ☐No

_____________________________________________          ____________________
Parent or Legal Guardian's Signature          Date

**Consent to Treat Minor**

Name of minor to be seen______________________________________________________

I agree to avail the above-named minor child into a counseling relationship with the understanding of the following conditions:

1) I understand that the minor's counseling records are kept confidential, except where disclosure is required by law (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others) or the minor has signed the appropriate release of information forms.
2) Counseling will cover emotional, physical and spiritual aspects of my life and may sometimes be distressing and difficult.
3) I have the right to discontinue therapy at any time with minor's consent. I understand terminating counseling is best decided after consulting with minor and minor's therapist.
4) I understand that *Life Counseling Center* does not accept insurance for partial or full payment of services rendered. I agree to pay $_____________________________ at the conclusion of each appointment.
5) Barring emergencies, I understand I must cancel and/or reschedule minor's appointments by notifying the office **at lease 24 hours** prior to the scheduled appointment hour. There will be a **charge** if appointment is cancelled within 24 hours of appointment time. If you do not call and do not show up for your appointment, the **full charge** will apply. In the evenings and on weekends, you may leave a message on our voice mail, which will accurately record the date and time of your call.
6) In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable *Life Counseling Center*, or employees of the aforesaid from any and all claims, demands, actions or causes of action of whatsoever kind and nature related to the counseling process.

*I have read and understood the preceding information and agree to the policies of Life Counseling Center as stated. I understand that these comments are prerequisite to minor's receiving and continuing counseling through Life Counseling Center.*

_______________________________________________________ ___________________

Parent's Signature Date

_______________________________________________________ ___________________

Therapist's Signature Date