



**Youth Intake Form-Parent Version**  
For parent(s) or caregiver(s) to fill out on behalf of/with their child

**Contact Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Youth E-Mail \_\_\_\_\_

Address \_\_\_\_\_ Youth Cell # \_\_\_\_\_

\_\_\_\_\_ Okay to text? \_\_\_\_\_

Gender \_\_\_\_\_ Pronouns \_\_\_\_\_

**Education and Employment Information**

School Name \_\_\_\_\_ Address \_\_\_\_\_

Highest Grade Completed \_\_\_\_\_ Current Grade Level \_\_\_\_\_

School successes \_\_\_\_\_

School struggles \_\_\_\_\_

Does your child have an IEP or 504 Plan? Do you find it helpful? \_\_\_\_\_

\_\_\_\_\_

Does your child have a job? If so, describe (hours, type of work, do they enjoy it?)

\_\_\_\_\_

**Family Information**

Parent(s) or Caregiver(s) information

Name(s) \_\_\_\_\_

Phone Number(s) \_\_\_\_\_

In Case of Emergency Call \_\_\_\_\_  
Name and Number if Different From Above

Who lives in your home? \_\_\_\_\_  
Parent, Grandparent, Friend, Pets

Race (Please check all that apply or add to the list)

- African American/Black
- American Indian/Native
- White
- Asian
- Native Hawaiian
- You Tell Me \_\_\_\_\_

Please write in the ethnicity, culture, nationality and religions you identify with or were born into below:

\_\_\_\_\_

### Medical and Mental Health Information

Primary Care Physician \_\_\_\_\_  
Name and Number

Other Medical Professionals Used (include contact information)

\_\_\_\_\_

Any Physical Health Concerns?

\_\_\_\_\_

\_\_\_\_\_

Any Mental Health Concerns? \_\_\_\_\_

\_\_\_\_\_

Please explain the biggest things in life that stress your child out:

\_\_\_\_\_

\_\_\_\_\_

Tell me about life changes or, any other things about your child's health and wellness:

\_\_\_\_\_

**Questions** below are best answered prior to the first appointment. If there are any questions that do not apply, skip them. If you would prefer to discuss an answer in person, please make a note and we will review this form together at your first appointment.

Why are you seeking counseling for your child at this time?

Has your child had counseling before? When and for how long?

Has your child ever been diagnosed with an illness, been in an accident, had a hospital stay or something else very difficult when they were young (particularly during the first 18 months)?

What do you think is the best part of your child's day or week?

What do you think is the most challenging part of your child's day or week?

Tell me about your child's friends. Do they have a best friend? Describe their relationship(s):

Has someone important to your child left their life? Please explain:

Has your child experienced loss due to adoption, death, serious illness? Please explain:

How is your child doing in school?

How would teachers describe your child?

How would your child describe themselves (please ask your child to answer)?

How does your child get along with adults? With peers?

Please describe your child's diet and activity level:

What is your favorite activity to do with your child?

What activities does your child enjoy doing the most (in general)?

What motivates your child at school, home or in the community?

What demotivates them? What does that look like when it happens (i.e. yelling, running, hiding etc.)?

What is a typical evening or weekend like at your home?

What is your child's biggest strength, skill or talent?

What helps your child relax?

What uplifts your child when they feel down?

Is there anything else you would like to share about your child?

Please circle the behaviors, characteristics, symptoms, problems or feelings that you have observed or have been reported to you by your child that have been causing them stress, pain or limiting them at home, school or work:

Sadness	Trembling	Internet	Siblings
Depression	Mood Shifts	Panic	Racism
Anxiety	Fatigue	Self-esteem	Sexism
Fear	Pain	Family	Power struggles
Aggression	Adoption	Relationships	Spiritual Beliefs
Anger	Parental Separation	Work	Homophobia
New School	Loss	Stomach aches	Parental Divorce
Avoiding People	Suicidal Thoughts	Teachers	Death
Disorganized	Loneliness	School	Moving
Impulsive	Recurring Thoughts	Bullying	Health changing
Irritable	Recurring Habits	Being the best	Flashbacks
Moody	Sick Often	Being the worst	PTSD
Communication	Hearing voices	Goal setting	Risk Taking
Strange Thoughts	Speech Problems	Hurting self	Assault
Alcohol Use	Hopelessness	Violence to others	Memory
Drug Use	Food/Eating	Transitions	Parents