Sullivan Counseling Inc.

New client information Intake Form (under 18)

The information you provide here is protected as confidential.

Name: _____

Name of person completing form (if different from above): _____

Today's date: _____

Date of Birth: _____ Gender: □ M / □ F

Parent's names: _____ _____

Address: _____

Home Phone:_____ May I leave a message? □ Yes □ No

Cell/Other Phone:_____ May I leave a message? □ Yes □ No

E-mail: _____ May I email you? □ Yes □ No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

How were you referred: _____

What has brought you here today?

_____

_____

_____

□ Depression
□ Anxiety
□ Obsessive-Compulsive behavior
□ Disturbing thoughts
□ Lack of energy
□ Low self esteem
□ Phobia
□ Trauma
□ Grief and Loss
□ Dramatic mood swings
□ Mania
□ School problems
□ Reduced activity level
□ Attention Deficit

□ Impulsive/poor judgment
□ Overly dependent
□ Disruptive behavior
□ Social skills deficits
□ Sensory dysfunction
□ Peer/Sibling conflict
□ Psychotic thoughts
□ Dissociation
□ Fire setting
□ Eating disorder
□ Self-mutilation
□ Gender identity issues
□ Alcohol/drug use
□ Other:_____

Comments related to any of the above: _____

_____

History of Mental Health Treatment:

_____

Current/Past Psychotropic Medications: _____

School Information

Grade:_____
Name of School:_____ District: _____

*(Check all that applies)***:**

Quality of Relationships with School Staff: □ cooperative / □ withdrawn / □ isolated / □ controlling □ behaviors / □ defiance / □ verbally aggressive / □ physically aggressive/other

Comments (if applicable):
_____
_____

Quality of Relationships with Peers at School: □ developmentally appropriate / □ cooperative □ friendly / □ withdrawn / □ isolated / □ controlling / □ victimized / □ bullies / □ verbally aggressive □ physically aggressive / □ other

Comments (if applicable):
_____
_____

Attendance (Number of days missed, truancy issues):
_____

Special Education (IEP): □ No / □ Yes Comments: _____

School Behaviors: □ enjoy school / □ follow rules / □ passing / □ separation problems / □ failing □ inattention / □ withdrawn/ □ hyperactivity / □ oppositional / □ irregular attendance / □ truancy □ disruptive behaviors / □ aggression / □ other _____

Comments (if applicable):
_____
_____

School Involvement (□ Clubs/Sports / □ Afterschool Activities / □ Mentoring):
_____
_____

History of Suspension or Expulsion: □ No / □ Yes: Comments: _____

Trauma/Psychosocial Risk Assessment: *Check and use "Comments" to describe*

Child abuse/sexual abuse/neglect:	□ not applicable	□ current	□ past
Exposure to domestic violence:	□ not applicable	□ current	□ past
History of out-of-home placement:	□ not applicable	□ current	□ past
At risk of out-of-home placement:	□ not applicable	□ current	□ past
Multiple moves:	□ not applicable	□ current	□ past
Victim of violence:	□ not applicable	□ current	□ past

Trauma/Psychosocial Risk Assessment: *Check and use "Comments" to describe*

Living in poverty:	□ not applicable	□ current	□ past
Familial substance abuse:	□ not applicable	□ current	□ past
Adjustment to serious illness in client:	□ not applicable	□ current	□ past
Adjustment to serious illness in family:	□ not applicable	□ current	□ past
Family history of mental illness:	□ not applicable	□ current	□ past
Impulsive/acting out:	□ not applicable	□ current	□ past
Legal difficulties:	□ not applicable	□ current	□ past
Sexual Acting Out:	□ not applicable	□ current	□ past

Comments:_____

*(Check all that applies)***:**

Sleep Patterns: □ normal range / □ disrupted nighttime sleep / □ sleeps in the day / □ difficulty falling asleep / □ difficult to arouse after sleep / □ frequent night terrors / □ frequent nightmares

Other comments:_____

Eating Patterns: □ normal range / □ very selective / □ very limited types of foods / □ not eating enough resulting in weight loss / □ overeating / □ binging / □ purging

Other comments:_____

Brief Medical History:

Current Physical Illness or Disability:_____

Current Medications: _____

History of Seizures: _____

Pain or Somatic Complaints: _____

Family Information:
Who lives in your home?

Name:	Relationship (ex. mother, brother, grandmother):	Age:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe your family's strengths: _____
_____
_____
_____

*(Check all that applies)***:**

Family's communication style: □ communicate directly/ □openly / □ communication skills regress under stress / □ communications are indirect/ □ misunderstood / □ communication is avoided
□ communication is abusive

Comments:_____

Family conflict: Frequency level: □ Infrequent / □ moderate / □ frequent
Severity level: □ minor / □ moderate / □ severe

Comments:_____

Spiritual/Cultural Assessment: Are there any spiritual or cultural considerations that would be helpful for me to know? □ No / □ Yes

Comments:_____