

# CLIENT INTAKE FORM - MINOR

Under the age of 18



Groff  
& Associates  
Professional Counseling

## Child's Information - Please print clearly - One person per section.

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Gender:  Male  Female

Cell Phone: (    ) \_\_\_\_\_ Child's Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Referred By: \_\_\_\_\_ Therapist Assigned: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Child's Mother - Please print clearly.

Responsible Party

Insurance Policy Holder

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Mother's Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cell Phone: (    ) \_\_\_\_\_ Referred By: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status:  Single  Married  Other Employer's Name: \_\_\_\_\_

May we  leave  messages identifying  our agency?

## Child's Father - Please print clearly.

Responsible Party

Insurance Policy Holder

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Father's Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cell Phone: (    ) \_\_\_\_\_ Referred By: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status:  Single  Married  Other Employer's Name: \_\_\_\_\_

May we  leave  messages identifying  our agency?

**NOTE:** If insurance is filed, by either Groff & Associates or yourself, all **standard billing rates** must apply. If you are paying a reduced rate and try to file an insurance claim on your own, it constitutes *insurance fraud* and we will not release the information needed by the insurance company to process the claim.

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**Instructions:** Please fill out questionnaire. Parents, please fill out for a young child.

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Some Days	More than half the days	Most every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or let your family down	0	1	2	3
7. Trouble concentrating on things like doing school work or watching television	0	1	2	3
8. Moving or speaking slowly that people have noticed	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to sleep or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid, as if something awful might happen	0	1	2	3

Column Totals Questions 1 - 9 \_\_\_\_\_

Column Totals Questions 10 - 16 \_\_\_\_\_

A) Has there been a time in the **past month** where you have had serious thoughts about ending your life?  
 Yes                       No

B) In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes?  
 Yes                       No

C) Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?  
 Yes                       No

D) If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do, your school work, take care of things at home or get along with other people?

Not difficult at all       Somewhat difficult       Very difficult       Extremely difficult