INNER AWAKENING COUNSELING & CONSULTATION
NEW CLIENT INTAKE FORM- Child

The Basics	
Name of Child:	Date of Birth
Full Address:	Phone:_____ Alternate:_____ Ok to leave messages? ❍ Yes ❍ No Text Reminders? ❍ Yes ❍ No
Name of Legal Guardian:	Relationship:
Email:	
How did you learn of Inner Awakening Counseling & Consultation?	
Briefly, what is the problem(s) for which you are seeking services today?	

Mental & Emotional Health Review
Has your child ever been diagnosed with a mental, behavioral, or personality diagnosis? If so, what, and when?
Has your child ever been in counseling or therapy? ❍ Yes ❍ No *If yes, approximately when and for what?*
Has your child been hospitalized due to a mental health emergency? ❍ Yes ❍ No
Family history of mental illness or personality disorders ❍ Yes ❍ No
Any history of trauma? ❍ Yes ❍ No
Any previous grief or loss history? Please list relationship and approximate date.
Is there a history of drug abuse or addiction? ❍ Yes ❍ No

Medical & Physical Health Review
Is your child under the care of a physician or other health practitioner? ❍ Yes ❍ No *For what?*
Last time had a physical by a physician (*approximate date)*:
Current medications, herbs, or other dietary supplements: _____ _____ _____ _____ _____ _____ _____ _____

Social Review	
Are there sufficient finances to meet your child's and family needs? ❍ Yes ❍ No	
What grade is your child currently attending:	
Learning or intellectual disabilities? ❍ Yes ❍ No	IEP? ❍ Yes ❍ No
Has your child had problems with bullying? ❍ Yes ❍ No *If yes, for what?*	
Other behavioral or academic problems at school?	
Has your child had involved with child protective services? ❍ Yes ❍ No	
Has your child been involved with the legal or judicial system? ❍ Yes ❍ No	
Does your child have difficulty with relationship with siblings? ❍ Yes ❍ No	
Does your child have difficulty with relationship with peers? ❍ Yes ❍ No	

Strengths & Resources
Is your child affiliated with a faith community, church, or spiritual group? ❍ Yes ❍ No
What does your child do to take calm themselves when upset?
Are you receiving support from other professionals or agencies? ❍ Yes ❍ No Describe:
Who are your child's closest supports?

Brief Symptom Review
Please identify which of the following symptoms your child's experienced. Circle **Current** for those symptoms that your child's experienced in the past month, or circle **Previously** for those your child's experienced, but not in the last month. You may circle both if both apply. Please be honest as this will help with formulating a more accurate diagnosis and the development of a treatment plan.
C P A difficult life event happened, and since then you've been experiencing some kind(s) of distress (mental, emotional, physical, social, or spiritual)
C P Sadness.
C P Hopelessness.
C P Fatigue or loss of energy.
C P Guilt.
C P Worthlessness.
C P Lack of interest or pleasure in activities.
C P Unintentional weight loss or weight gain. How much_____?
C P Attempts or thoughts of killing yourself.
C P Attempts or thoughts physically injuring your body to feel better.

C P Attempts or thoughts of killing someone else.
C P Excessive energy and high productivity.
C P Feeling on top of the world.
C P Racing thoughts.
C P Decreased need for sleep compared to your normal.
C P People say you dress inappropriately, seductively, or bizarrely.
C P Bursts of intense or excessive anger.
C P Engaging in behaviors or activities that you are told are risky or dangerous.
C P Decreased appetite.
C P Easily impatient or irritable.
C P Impulsive.
C P Disciplinary troubles at school or work.
C P Rapid mood swings.
C P Difficulty following through with tasks and projects.
C P Easily distracted.
C P Forgetfulness.
C P Difficulty concentrating or focusing.
C P Difficult problem solving or decision-making.
C P Difficulty being able to remain calm and still
C P Continual worry about a wide variety of routine or mundane things.
C P Feeling physically restlessness, tension, shaking, or on edge.
C P Periodic episode of intense anxiety and fear.
C P Episodes where you felt like you might be having a heart attack.
C P Fear of going places because of the episode of intense anxiety.
C P Intense fear of certain places, animals, activities, or things.
C P Engage in repetitive behavior that causes you distress if you don't complete.
C P Having repetitive thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing.
C P Avoidance of certain activities, places, or environments.
C P Fear of something terrible happening to you or a loved one.
C P Intrusive thoughts or memories.
C P Experiences of feeling like you are re-living something awful.
C P Nightmares.
C P Been exposed to possibility of death or fear of dying or serious harm.
C P Feeling detached or disconnected from others.
C P Easily startled.
C P Always on guard.
C P Fear of gaining weight or getting fat.
C P Belief that you are fat.
C P Been told you are too skinny or that you need to gain weight.
C P Regular use of laxatives, diuretics, weight loss supplements, or frequent attendance at gym or other weight loss activities.
C P Periods of gorging yourself on food and then throwing up, using laxatives, or other activity to make up for it
C P Episodes of hearing, seeing, or sensing things that you think, or others tell you, may not be real
C P Having beliefs or thoughts about reality that you wonder if, others tell you, are not reality or the way things really are.
C P Extended periods of time in your memory that are blank.
C P Evidence emerges related to behaviors of which you have no memory.
C P Been told you sometimes call yourself by other names and act very differently but have no memory of this.

C P Difficulty maintaining close, emotional relationships.
C P Fear that others will abandon you if they get to know the "real" you.
C P Difficulty letting go of past wrongs against and holding grudges
C P Feeling undervalued by others, and/or needing to show others your value
C P Feeling that others want to undermine, sabotage, or take advantage of you.
C P Difficulty feeling remorse when you've done something wrong.
C P Difficulty feeling empathy or being able to relate to other people.
C P Difficulty with establishing & maintaining relationships at school, work, or within your family
C P Difficulty functioning in social environments and relating to people

Signature

_____ _____
Name- Print **Name- Signature**

_____
Date

Reviewed by

_____ _____
Name, credentials, title- Print **Name- Signature**

_____
Date