New Leaf Therapy, LLC
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Youth Intake Information

Please fill out this form and bring it to your first session.

Client's Name _____ Date_____

Preferred First Name_____

DOB_____ Age_____ Sex_____ SSN_____

Parent/Guardian Name(s)_____

Address_____ _____ _____ _____
Street City State Zip Code

Home Phone _____ Is it ok to leave a message? _____ (Y/N)

Cell Phone_____ Is it ok to leave a voice mail? _____ (Y/N)

Is it ok to send a text? _____ (Y/N)

Email_____ Is it ok to send an email? _____ (Y/N)

Check your preferred contact method(s): ☐ *Home phone* ☐ *Cell Phone* ☐ *Text* ☐ *Email*

Emergency Contact_____ _____ _____
Name Relationship Phone

Family Physician_____ _____
Name Phone

School_____ Grade_____

Are they receiving any special services or resource classes? _____

Do they have an IEP or 504 Plan? _____ (Y/N)

How are their grades? *(Check One)* ◯ *Above Average* ◯ *Average* ◯ *Below Average*

How did you hear about New Leaf Therapy? _____

What preferences do you have for days and times of appointments? _____

INSURANCE INFORMATION:

Insurance Company_____ Phone Number_____

Insurance ID Number_____ Group Number_____

Primary Subscriber_____ Relationship to Client_____

Primary Subscriber's Birthday_____

___ (Y/N) **Have they previously received any type of mental health services (counseling, psychiatrist)?**
If yes, provide therapist/psychiatrist name, phone number, and dates they received services.

___ (Y/N) **Are they currently taking any prescription medications?** If yes, please list

___ (Y/N) **Have they ever been hospitalized at an in-patient treatment facility for psychological/emotional problems?** If yes, please give location(s), date(s), and diagnoses

___ (Y/N) **Have they ever intentionally caused harm to themselves or are they currently thinking about it?**
If yes, describe

___ (Y/N) **Are they currently experiencing any physical health problems?** If yes, please list

How many times a week does he/she exercise? _____

What types of exercise does he/she enjoy? _____

What hobbies/activities do they enjoy? _____

Is your child currently struggling with using alcohol/nicotine/recreational drugs? If so, please list the substance(s) and frequency of use.

Is your child currently pregnant? _____ (Yes/No/Unsure)

What are your child's strengths?

_____

PROBLEM ANALYSIS

Briefly describe the problem(s) or concern(s) that you would like your child to get help with in counseling:

What have you already tried to do to resolve or cope with this problem?

What significant life changes or stressful events has your child experienced recently?

Please list the names, relations, and ages of those living in the household:

Please list any significant mental health problems immediate and extended family members have:

What stressors is your family currently experiencing?

Are there issues your family needs to work on together? If so, please describe:

SYMPTOM CHECKLIST: *Please check off any symptoms your child has experienced in the past month.*

- ☐ Depressed Mood
- ☐ Grief
- ☐ Panic Attacks
- ☐ Anxiety/Fear
- ☐ Test Anxiety
- ☐ Loss of Interest or Pleasure in Activities
- ☐ Extreme Weight Loss/Gain
- ☐ Change in Appetite
- ☐ Purposely Throwing Up
- ☐ Exercising Excessively
- ☐ Insomnia
- ☐ Sleeping More Than Normal
- ☐ Nightmares
- ☐ Frequently Tired
- ☐ Racing Thoughts
- ☐ Easily Startled
- ☐ Flashbacks/Intrusive Memories
- ☐ Obsessions _____
- ☐ Compulsions _____
- ☐ Isolating themselves
- ☐ Bed-wetting
- ☐ Cutting/Hurting Themselves
- ☐ Thinking About Suicide
- ☐ Hallucinations/Delusions
- ☐ Phobias _____
- ☐ Difficulty Concentrating/Making Decisions
- ☐ Difficulty Sitting Still
- ☐ Difficulty Organizing
- ☐ Difficulty Focusing on Tasks
- ☐ Feeling Unwanted/Unloved
- ☐ Feeling Guilty/Ashamed
- ☐ Feeling Hopeless/Empty
- ☐ Low Self-Esteem
- ☐ Relationship Problems
- ☐ Restless
- ☐ Defiant
- ☐ Refusing to Obey Adults
- ☐ Physically Violent
- ☐ Lack of Empathy for Others
- ☐ Extreme Mood Shifts
- ☐ Irritable/Easily Angered
- ☐ Risky/Unsafe Decision-Making
- ☐ Feeling Overwhelmed
- ☐ Frequent Crying
- ☐ Being Bullied
- ☐ Academic Problems
- ☐ Friend Problems
- ☐ Addictions_____
- ☐ Loss of _____
- ☐ Other_____

☐ Struggling with Past Trauma, please describe type of trauma:

Who does the client get along with best? _____

Who doesn't the client get along with well? _____

Would you be interested in having some family counseling sessions? _____ *(Yes/No/Unsure)*

What do you hope will be accomplished in therapy?

Please share any other pertinent information:

Please sign below to indicate that the information provided is true and correct:

_____

Print Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date