



Youth Intake Form-Parent Version

For parent(s) or caregiver(s) to fill out on behalf of/with their child

Contact Information

Name _____ Date _____

Address _____ DOB _____

Okay to text? _____

Youth E-Mail _____ Youth Cell # _____

Gender _____ Pronouns _____

How did you find me? _____

Education and Employment Information

School Name/Location _____

Highest Grade Completed _____ Current Grade Level _____

School successes _____

School struggles _____

Does your child have an IEP or 504 Plan? Do you/they find it helpful?

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

Please describe interactions/activities at home _____

Medical and Mental Health Information

Please list any physical or mental health concerns I should be aware of:

Please describe any other important information about your child's health and wellness:

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 experienced something very difficult, scary, confusing or life threatening? If so, at what age?

Has your child ever experienced any major life changes (moving, changing schools, loss of friend or relative)? When did this happen?

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
Transphobia	Speech Problems	Hurting self	Assault
Alcohol Use	Hopelessness	Violence to others	Memory
Drug Use	Food/Eating	Transitions	Parents

Please use this space to share anything else you would like to share about your child: