BrightWay Counseling & Wellness

Intake Survey- minor

Child Name:______________________________ Age:_______________

Date of Birth:______________________ Grade:_________ Passing? Yes / No

Address: ____

School Attending: ____

Doctor: ______________________________ Doctor's Phone Number ______________________

Siblings of child:

1. ______________________________ **m / f** **Age:________**
2. _______________________________ **m / f** **Age:________**
3. _______________________________ **m / f** **Age:________**
4. ________________________________ **m / f** **Age:_________**

Parent information

Mother: ____________________________ Age:________

Please circle one:

Biological	**Adoptive** **age of child when adopted?**	**Step parent** **Age of child when married?**

Address:____

Phone:______________________ Cell Phone ______________________Email:_________________

Place of employment /occupation:_________________________________

Father __________________________________ Age:__________

Please circle one:

Biological	**Adoptive** **age of child when adopted?**	**Step parent** **Age of child when married?**

Address: (if different from above) ____

Phone _______________________ Cell Phone:_____________________Email:_________________

Place of employment/occupation:____

Please list everyone that currently lives in your home:

____

____

Medical
Is your child currently receiving any medical/mental health/other mental health treatment?
Yes No
If so, where?:____

List all areas/conditions being treated:____-

List any prescribed medications client is currently taking:
____

____

List any over the counter medications or supplements that client currently takes:
____

Has client ever been diagnosed with a learning disorder or mental/emotional disorder? **Yes/ No**
If so, please specify:

Are there any medical or mental health conditions that occur in your family? **Yes No**
If so, list all and the relevant family member/relation to client.

Who may I thank for referring you to my practice?
____

What do you hope for counseling to accomplish with your child or in your family?

Please list your immediate concerns in order of importance:
1.
2.
3.
4.
5.

Please include anything else you feel is important regarding your child or your family:

Parent/ Guardian signature____________________________ Date:_______________________