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

Address:_____

Phone:_____ Cell Phone _____Email:_____

Place of employment /occupation:_____

Father _____ Age:_____

Please circle one:
Biological **Adoptive** **Step parent**
age of child when adopted? **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:**_____