

Karen Nam, LCSW (OR # L5719)

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### Minor Intake Questionnaire

Date \_\_\_\_\_ Child/Teen's Name \_\_\_\_\_ DOB: \_\_\_\_\_

Names of all parents/guardians/stepparents who reside with child:

\_\_\_\_\_  
\_\_\_\_\_

Home address \_\_\_\_\_

Cell phone number (area code included) \_\_\_\_\_

Home phone number (area code included) \_\_\_\_\_

Email address \_\_\_\_\_

Please provide emergency contact information [name, address, phone number(s)]:

\_\_\_\_\_

Name(s) and ages of any sibling(s). Please include step and half-siblings:

\_\_\_\_\_  
\_\_\_\_\_

Pets \_\_\_\_\_

Name of school \_\_\_\_\_

Grade \_\_\_\_\_ Teacher's name \_\_\_\_\_

Is your child taking any medication/s? yes no  
If so, please indicate which type

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Does your child have any health problems? yes no  
If so, please describe

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***This section to be filled out by children ages 12 and up:***

Have you ever been in counseling before? yes no  
If so, when? Was it helpful? \_\_\_\_\_

Have you ever tried alcohol, cigarettes, marijuana, or any other drugs? yes no

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For Girls: At what age did you start menstruation? \_\_\_\_\_  
For Boys and Girls:

Have you ever tried to hurt yourself? yes no

Have you ever cut on yourself? yes no

Have you ever thought about wanting to die? yes no

Have you ever thought your parents or friends would be better off without you?  
yes no

Do you have problems sleeping? yes no

Do you have problems with your peers or friends? yes no

Do you worry about your weight or think you are too thin or too fat? yes no

Is there anything else you would like me to know about you

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