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

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

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

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

Karen Nam, LCSW