INTAKE FORM – MINOR (under the age of 18)

Date: _____

Minor's Information

Last Name: _____ First Name: _____ MI: _____

Birth date: _____ Gender: ____ Male ____ Female

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____ E-mail address:_____

Referred By (if applicable): _____

Information of Minor's Mother

___ Responsible Party (?) ___ Insurance Policy Holder (?)

Last Name: _____ First Name:_____ MI:_____ Birth Date: _____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____ E-mail address:_____

Marital Status: ___Single ___Married ___Other

Employer's Name: _____

May we leave messages identifying our agency? ____Yes (at home) ____ Yes (on cell phone) ____No

Information of Minor's Father

___ Responsible Party (?) ___ Insurance Policy Holder (?)

Last Name: _____ First Name:_____ MI:_____ Birth Date: _____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____ E-mail address:_____

Marital Status: ___Single ___Married ___Other

Employer's Name: _____

May we leave messages identifying our agency? ____Yes (at home) ____ Yes (on cell phone) ____No

Instructions: Please fill out the following questionnaire. Parents, please fill out if minor is a young child.

Over the last 2 weeks, how often have you been bothered by the following?	Not at all	Some Days	More than half the days	Most every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or let your family down	0	1	2	3
7. Trouble concentrating on things like doing school work or watching television	0	1	2	3
8. Moving or speaking slowly that people have noticed	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to sleep or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid, as if something awful might happen	0	1	2	3

Column Totals Questions 1 – 9 _____ **Column Totals Questions 10 - 16** _____

A) Has there been a time in the **past month** where you have had serious thoughts about ending your life?
[ ] Yes [ ] No

B) In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

C) Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

D) If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do, your school work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult