NEW HOPE
COUNSELING

INTAKE FORM (MINOR – under the age of 18)

Date: _____

How did you hear about New Hope Counseling?

Redeemer Presbyterian Church ____	Fountain Square Presbyterian Church ____	Midtown ____
SOMA ___	Christ Community ____	Referred by friend ____
Campus Outreach _____	Online search ____	Other *(please specify)* _____

Minor's information:

Last Name: _____ First Name: _____ MI: ___

Date of Birth: _____ Gender: Male ____ Female ____

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

Home:(____)_____ Cell:(____) _____ Email Address: _____

Information of Minor's Mother

_____ Responsible Party (Y/N) ____ Insurance Policy Holder (Y/N)

Last Name: _____ First Name: _____ MI: ___

Date of Birth: _____ Marital Status: Single____ Married____ Other____

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

Home:(____)_____ Cell:(____) _____ Work:(____) _____

Email Address: _____

Employer's Name:_____

Information of Minor's Father

_____ Responsible Party (Y/N) ____ Insurance Policy Holder (Y/N)

Last Name: _____ First Name: _____ MI: ___

Date of Birth: _____ Marital Status: Single____ Married____ Other____

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

Home:(____)_____ Cell:(____) _____ Work:(____) _____

Email Address: _____

Employer's Name:_____

Payment information:

PLEASE INITIAL _____ New Hope Counseling may electronically store my credit card information.

PLEASE INITIAL _____ New Hope Counseling may automatically charge my credit card for appointments and/or for no show/late cancellation charges.

Health information:

Date of last physician visit: _____ What was the purpose of this visit? _____

Please list any medications minor is currently taking:

Medication	Dosage/frequency	Results

Please list any previous therapy or treatment minor has received from mental health professionals:

Date(s)	Counselor name / place of therapy	Nature of problem / reason for seeking therapy	Result of treatment

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 reading the newspaper or watching TV	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 _____

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

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

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

If you are experiencing any of the above 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? *Please circle one:*

Not difficult at all Somewhat difficult Very difficult Extremely difficult