Minor Intake Form

Client's name: ____ Date: _____/_____/______ SSN: _____/_____/______

Gender: ___F ____M ___Other Date of Birth: ____/____/____ Age: _____ Grade in school: _________________

Form Completed by: ____

Phone # (H) ____ (C) ____

May I leave you a voicemail? Y / N May I text you? Y / N May I email you? Y / N

Address: ____ City: __________________ State: ______ Zip: ___________

Email address: ____

Emergency Contact: ____ Relationship: ______________________________

Phone # (H) _____________________________ (C)____________________________ Work ___________________________

Who referred you to this Program? Self Family Primary Doctor Therapist Insurance Website Friend

PERSONAL HISTORY – CHILDREN & ADOLESCENTS

If you need any more space for any of the following questions, please use the back of the sheet.

Primary reason(s) for seeking services:

___Anger management ___Anxiety ___Coping ___Depression

___Eating Disorder ___Fear/Phobias ___Mental Confusion ___Sexual Concerns

___Sleeping problems ___Addictive behaviors ___Alcohol/drugs ___Hyperactivity

___Other mental health concerns (specify): ____

____

What are your goals for your child's therapy? ____

____

FAMILY HISTORY

PARENTS

With whom does the child live at this time? ____

Are the parent's divorced or separated? ____

If yes, who has legal custody? ____

Please explain further ____

Were the child's parents ever married? ____Yes ____No

Revised 7/25/2015

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ____ Yes ____ No If yes, describe: ____

____

FAMILY HEALTH HISTORY

Have any of the following diseases occurred among blood relatives? (Parents, siblings, aunts, uncles, or grandparents)

Check those that apply:

___Allergies	___Cerebral Palsy	___Heart Diseases	___Multiple Sclerosis
___Anemia	___Cleft lips	___High Blood Pressure	___Muscular Dystrophy
___Asthma	___Cleft Palate	___Kidney Disease	___Nervousness
___Bleeding tendency	___Deafness	___Mental Illness	___Perceptual motor disorder
___Blindness	___Diabetes	___Mental Retardation	___Seizures
___Cancer	___Glandular problems	___Migraines	___Spinal Bifida
___Suicide	___Other (specify): ________________		

Comments regarding Family Health: ____

HEALTH

List any current health concerns for the child: ____

____

List any recent health or physical changes: ____

____

Please check if there have been any recent changes in the following:

___Sleep patterns	___Eating patterns	___ Behavior	___ Energy level
___Physical activity level	___General disposition	___Weight	___Nervousness/tension

Describe changes in areas in which you checked above: ____

____

MEDICATIONS

Allergic to any medications or drugs? ___Yes ___No

If yes, describe: ____

____

Current prescribed medications	Dose	Dates	Purpose	Side Effects
______________________	_______	_______	____________	____________________
______________________	_______	_______	____________	____________________
______________________	_______	_______	____________	____________________

Revised 7/25/2015

CHEMICAL USE HISTORY

Does your child use or have a problem with alcohol or drugs? _____ Yes _____ No

If yes, describe: ____

____

FEELINGS ABOUT SCHOOL WORK

____Anxious	____Passive	____Enthusiastic	____Fearful
____Eager	____ No Expression	____Bored	____ Rebellious

____Other (describe): ____

COUNSELING/PRIOR TREATMENT HISTORY

Information about yourself (past and present):

	Yes	No	When	Where	Reaction to overall Experience
Counseling/Psychiatric Treatment	____	____	____________	______________	______________________________
Suicidal thoughts/attempts	____	____	____________	______________	______________________________
Drug/Alcohol treatment	____	____	____________	______________	______________________________
Hospitalization	____	____	____________	______________	______________________________
Involvement with self-help	____	____	____________	______________	______________________________
Groups (e.g. AA, AL-Anon, NA,	____	____	____________	______________	______________________________
Overeaters Anonymous)	____	____	____________	______________	______________________________

For Office Use Only

Therapist's comments: ____

____

____

Therapist's signature/credentials: ____________________________ Date: ____/____/____

Supervisor's comments: ____

____

Physical exam: Not required

Supervisor's signature/credentials: ____________________________ Date: ____/____/____

(Certifies case assignment, level of care)

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MINOR CONSENT & AGREEMENT

MINOR CONSENT

Please check below to indicate the current situation regarding the custody of the minor child:

___ Parents are married to each other and are the legal parents of the child (one signature required)

If parents are divorced and only one signature is present, a copy of the Custody Agreement court documents and a note from a physician supporting counseling based on medical necessity are both required a minimum of 1 business day prior to intake – copies of these documents must be present in the client file (Court documents are also required when a guardian or the State has legal custody)

___ My ex-partner / spouse and I share legal custody of the child *(both signatures required)*
___ I am a single parent and have full legal custody of the child *(one signature required)*
___ I am a non-parent legal guardian and have full legal custody of the child (one signature required)
Legal Guardianship court documents are required at intake – a copy must be in the client file
___ The child is in the custody of the State of New Mexico. County ____ *Court Documents are required at intake – a copy must be present in the client file*

- I understand that at least one parent must accompany the minor child to his/her first appointment and any subsequent appointments, until discussed with and agreed upon with the therapist.
- I understand that Herndon Consulting, LLC DBA BeMeBetter does not give the recommendations or do evaluations for child custody or parenting. If this becomes an issue, my child's case may be closed,
- I hereby grant my permission for my minor child to be treated by Herndon Consulting, LLC DBA BeMeBetter. This permission will remain in force until revoked by me.

LEGAL GUARDIAN SIGNATURE: ____ DATE: ____/____/____

LEGAL GUARDIAN SIGNATURE: ____ DATE: ____/____/____

MINOR AGREEMENT

The involvement of children and adolescents in therapy can be highly beneficial to their overall development. Very often, it is best to see them with parents and other family members; sometimes, they are best seen alone. The therapist will assess which might be best for your child and make recommendations to you. Obviously, the support of all the child's caregivers is essential, as well as their understanding of the basic procedures involved in counseling children.

The general goal of involving children in therapy is to foster their development at all levels. At times, it may seem that a specific behavior is needed, such as to get the child to obey or reveal certain information. Although those objectives may be part of overall development, they may not be the best goals for therapy. Again, the therapist will evaluate and discuss these goals with you.

Because the role is that of the child's helper, the therapist will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. *Matters involving custody and mediation are best handled by another professional who is specially trained in those areas, rather than by the child's therapist.*

The issue of confidentiality is critical in treating children. When children are seen with adults, what is discussed is known to those present and should be kept confidential except by mutual agreement. Children seen in individual sessions (except under certain conditions) are not legally entitled to confidentiality (also called privilege); their parents have this right. However, unless children feel they have some privacy in speaking with a therapist, the benefits of therapy may be lost. Therefore, it is necessary to work out

an arrangement in which children feel that their privacy in generally respected, at the same time that parents have access to critical information. This agreement must have the understanding and approval of the parents or other responsible adults and of the child in therapy.

This agreement regarding treatment of minors has provisions for inserting individual details, which can be supplied by both the child and the adults involved. However, it is first important to point out the exceptions to this general agreement. The following circumstances override the general policy that children are entitled to privacy while parents or guardians have a legal right to information.

- Confidentiality and privilege are limited in cases involving child abuse, neglect, molestation, or danger to self or others. In these cases, the therapist is required to make an official report to the appropriate agency and will attempt to involve parents as much as possible.
- Minors may independently enter into therapy and claim the privilege of confidentiality in cases involving abuse, severe neglect, molestation, pregnancy, or communicable diseases, and when they are on active military duty, married or officially emancipated. They may seek therapy independently for substance abuse, danger to self or others, or a mental disorder, but parents must be involved unless doing so would harm the child.
- Any evaluation, treatment, or reports ordered by, or done for submission to a third party such as a court or a school is not entirely confidential and will be shared with that agency with your specific written permission. Please also note that the therapist does not have control over information once it is released to a third party.

AGREEMENT

I understand that the normal procedure for discussing issues that are in my child's/children's therapy will be joint sessions *including my child/children*, the therapist, and me and perhaps other appropriate adults. If I believe there are significant health or safety issues that I need to know about, I will contact the therapist and attempt to arrange a session with my child/children present.

Similarly, when the therapist determines that there are significant issues that should be discussed with parents, every effort will be made to schedule a session involving the parents and the child/children. I understand that if information becomes known to the therapist and has a significant bearing on the child's/children's well-being, the therapist will work with the person providing the information to ensure that both parents are aware of it. In other words, the therapist will not divulge secrets except as mandated by law, but may encourage the individual who has the information to disclose it for therapy to continue effectively.

I will do my best to ensure that therapy sessions are attended and will not inquire about the content of the sessions. If my child prefers/children prefer not to volunteer information about the sessions, I will respect his/her/their right not to disclose details. Basically, unless my child has/children have been abused or is/are a clear and present danger to self or others, the therapist will normally tell me only the following:

- Whether sessions are attended
- Whether or not my child/children are generally participating
- Whether or not progress is generally being made

LEGAL GUARDIAN SIGNATURE: ____ DATE: ____/____/____

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