Juneau County Department of Human Services
Outpatient Counseling Services Pre-Intake: Child/Adolescent

Form Completed by: ______________________ Date: ______________

Your relationship to minor: ☐ Biological Parent ☐ Adoptive Parent ☐ Foster Parent
☐ Step parent ☐ Other: ______________________

GENERAL INFORMATION

Name: ______________________ Date of Birth: ______________

Address: ____
Street, City, State, ZIP Code

CONTACT INFORMATION

Parent/Guardian Name: ______________________

Primary Number: ______________ Secondary Number: ______________
☐ Home ☐ Work ☐ Cell ☐ Home ☐ Work ☐ Cell

Email Address: ______________________

INSURANCE INFORMATION

<u>Primary Insurance</u>
Name of Policyholder: ______________________ Policyholder's DOB: ______________

Insurance Company: ______________________

ID #: ______________ Group #: ______________

<u>Secondary Insurance</u>
Name of Policyholder: ______________________ Policyholder's DOB: ______________

Insurance Company: ______________________

ID #: ______________ Group #: ______________

DEMOGRAPHIC INFORMATION

Gender: ______________ Preferred Pronouns: ______________

Race: ☐ American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

School/Grade: ______________________ Teacher: ______________

IEP: ☐ Yes ☐ No 504 Plan: ☐ Yes ☐ No

Your responses to the following questions will help determine which provider may best meet your child/adolescent's needs. Incomplete sections may delay our assigning process. If you need more space, please include additional paper.

What service(s) are you seeking?

☐ Mental Health Counseling ☐ Substance Use Treatment

☐ Mental Health Counseling with Psychiatry (medication prescribing)

☐ Mental Health Counseling with Substance Use Treatment

Why are services being requested at this time? *Check all that apply.*

☐ Behaviors at home ☐ Behaviors at school ☐ Performance at school

☐ Family problems ☐ Peer problems ☐ Overactive

☐ Grieving ☐ Sadness/Depression ☐ Temper tantrums

☐ Anger ☐ Mood swings ☐ Irritability

☐ Anxiety or worry ☐ Lack of self-confidence ☐ Unusual fears/phobias

☐ Sexual behaviors ☐ Self-destructive/harmful behavior

☐ Physical abuse ☐ Sexual abuse ☐ Emotional abuse

☐ Difficulty separating from parent ☐ Parents divorced/separated

☐ Eating disorder ☐ Alcohol/Drug use ☐ Bedwetting

☐ Witnessed domestic violence ☐ Witnessed traumatic event

☐ Difficult sleeping ☐ Nightmares ☐ Sleepwalking

☐ Other: ____

Explain checked reasons: ____

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How long has this been occurring? ____

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Who is their Primary Care Physician/Facility? ____

Is minor currently pregnant? ☐ Yes ☐ No ☐ NA

List all current prescription medications. Include name of medication, dose, and frequency.

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Is there any allergies or medical conditions you feel we should be aware of? ________________________

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What is their current mental health diagnosis? ____

Diagnosed by: ________________________________

List all previous mental health/psychiatric counseling/services/hospitalizations. Include facilities, providers, and dates.

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Is there a history of suicidal thoughts? ☐ No ☐ Yes

If yes, have they had attempts? ☐ No ☐ Yes; how old were they? _______________

List all previous Substance Use Treatment services. Include facilities, providers, and dates.

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Is minor using alcohol or drugs (other than prescribed)? ☐ Yes ☐ No ☐ Unknown

If yes, what are they using/taking? ____

Family history of alcohol or drug abuse: ____

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Family history of physical/sexual/domestic/emotional abuse: ______________________________

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Family history of mental health concerns/struggles: _____________________________________

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Was the minor's delivery considered normal? If not, explain: ______________________________

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Were drugs or alcohol used during pregnancy? If yes, what was used? ____________________

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Have there been any concerns for their development? If yes, explain: ____________________

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Is there any legal involvement with probation/parole or current/pending charges? ☐ Yes ☐ No

If yes, describe: ____

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Continue to last page.

We can accommodate disabilities. Please let us know if they have specific needs.

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Any other information or concerns you would like their therapist to know to better serve them?

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Thank you for taking the time to complete this pre-intake. The information provided will help determine appropriate services to meet your child/adolescent's needs.

MANAGER/PROVIDER – please complete and return to Intake Clerk

Assigned to: ________________________________

Intake Scheduled for: _________________________ at ________________
Date Time