

Emily Moen, Certified Counselor
206-659-9957
Emily@EmilyMoencounseling.com
snocounseling.com
207 Ave D, Suite 100
Snohomish, WA 98290

Client Intake Form – Child/Adolescent

*Please fill in the information below and bring it with you to your first session.
Please note: information provided on this form is protected as confidential information.*

CLIENT INFORMATION

Name _____ Preferred Name _____

Date of Birth _____ Age _____

Sex _____ Gender/Preferred Pronouns _____

Address _____

Parent / Legal Guardian (If under 18) _____

Parent / Legal Guardian (If under 18) _____

Parent Contact Phone Number _____

Parent Contact E-Mail Address _____

Client Contact Phone Number _____

Contact E-Mail Address _____

Ethnicity _____ Religion _____

Emergency Contact Information

EMERGENCY CONTACT NAME _____

* Please note, as stated in the "Safety" section of the disclosure statement, if I believe you are in danger of harming yourself, disclosure will be made to the listed emergency contact *

Emergency Contact Phone Number(s) _____

Relationship to Client _____

SCHOOL INFORMATION

School Name _____

Grade _____ 504 Plan? IEP? Other Special Services? _____

Extra Curricular Activities/Hobbies/Sports? _____

Do you enjoy school? YES NO SOMETIMES

Best part? _____

Worst part? _____

Goals/hopes after High School? _____

Client Health History

Name of primary care doctor: _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results: _____

Name of Psychiatrist: _____ Phone: _____

Last visit was during the month of: _____ Year: _____

Results: _____

Would you like me to coordinate with current providers? Yes No

Have you been diagnosed with any physical health problems?

Any significant allergies? _____

Mental Health History

Previous Mental Health diagnosis: _____

History of alcohol / drug use? Yes No Describe: _____

Has the client ever been hospitalized for psychiatric reasons? Yes No

If yes, when? _____

Has the client ever made a plan to commit suicide or attempted suicide?

Yes No If yes, when? _____

Does the client currently have thoughts of ending their life? Yes No

History of Mental Health Services - list age(s) & provider:

History of Psychiatric medication Yes No

List:

Please list additional information you would like me to know:

Current Mental Health

Current Medications: _____

Please check following symptoms or issues that apply to the client:

- | | | |
|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Behavior at home |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Sexuality | <input type="checkbox"/> Behavior at school |
| <input type="checkbox"/> Drug/Alcohol Use | <input type="checkbox"/> Anger | <input type="checkbox"/> Worry/Fear |
| <input type="checkbox"/> Self-esteem | <input type="checkbox"/> Abuse | <input type="checkbox"/> Strained relationship(s) |
| <input type="checkbox"/> Sleep Changes | <input type="checkbox"/> Cutting/Self-Harm | <input type="checkbox"/> Suicidal Thoughts |
| <input type="checkbox"/> Health Concern | <input type="checkbox"/> Life Change | <input type="checkbox"/> Grief and Loss |
| <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Trauma | <input type="checkbox"/> Decision Making/self control |
| <input type="checkbox"/> Focus/Attention | <input type="checkbox"/> Lack of motivation | <input type="checkbox"/> Divorce/Separation |

How intense is your emotional distress? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

To what degree do your problems affect your ability to perform at school, at home, and in your relationships with others? (Where 0 is not at all and 10 is incapacitating.)

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

When did these problems begin, and what was happening in your life at that time?

Current Habits

Please describe your current habits in each of the following areas:

- Nicotine use: _____
- THC use: _____
- Other drug use: _____
- Alcohol use: _____
- Caffeine intake: _____
- Exercise: _____
- Eating: _____
- Sleeping: _____
- Fun and relaxation: _____

Client Interest in Counseling Services

Please describe what brings you (or your child/teen) to counseling:

What are your goals for counseling? What would you like to achieve by attending counseling?

How motivated do you feel to work on your goals? Do you have concerns about counseling or working on these issues?

What are your positive qualities and skills? What do you like about yourself? What qualities have helped you to succeed at overcoming difficulties in the past?

Form completed by: _____ Date: _____

Signature: _____