FORWARD MOVEMENT COUNSELING CENTER
8105 RASOR BLVD SUITE 250
PLANO, TEXAS 75024
469-854-9867

Today's Date: ________________

Client Information

Name: ____
Last Name First Name Middle Name Nickname

Address:____ ________
Street City State Zip

Date of Birth:______________________________ Age:_________ Grade:_______Gender: ________

Parent/Guardian Information

Parents: ☐Married ☐Separated ☐Divorced ☐Remarried ☐Other___________________ ________

Email Address:____________________________________

May I send appointment reminders via email? ☐Yes ☐ No

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Minor Intake Form

Guardian 1:______________________________________ ____________ _______
Last Name First Name MI Relationship to Child

Address:____ _____________________ _______
Street City State Zip

Home Phone ______________________ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No
Work Phone Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No
____

Guardian 2:___
Last Name First Name MI Relationship to Child

Address:____________________ ____________________ _____________________ _______
Street City State Zip

Home Phone______________ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Cell Phone__________________________ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Email Address:____________________________________ ______________
May I send appointment reminders via email? ☐Yes ☐ No

____

Work ______________________ Phone Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

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Cell Phone__________________________ Call: ☐Yes ☐ No

Email Address:____________________________________ _____________________

May I send appointment reminders via email? ☐Yes ☐ No

Guardian 3:_____________________________________ ____________ _______

Last Name First Name MI Relationship to Child

Address:____ _____________________ _______

Street City State Zip

Home Phone ______________________ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Work : ______________________
Phone Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Cell Phone__________________________ Call: ☐Yes ☐ No Leave Message: ☐Yes ☐No

Email Address:____________________________________ _______

May I send appointment reminders via email? ☐Yes ☐ No

With whom does the child predominantly live?

Name Sex Age Relationship to child

____

____

____

____

____

If the child has a secondary home, who lives there?

Name	Sex	Age	Relationship to child

Emergency Contact: Whom should we contact in case of an emergency?

Name: ____ Relationship: _______________________

Address:____

Home Phone: ______________________________ Cell Phone:_______________________________________

Personal Information

Is your child currently in counseling with another therapist? ☐ Yes ☐ No

If "Yes" please describe____

Has your child ever received counseling or evaluation services? ☐ Yes ☐ No

If "Yes" please describe____

Have you or your child ever been involved in any type of litigation? ☐ Yes ☐ No

If "Yes" please describe____

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How would you rate your child's health?____________________________________

How many hours does your child sleep at night? ______________________

How would you rate your child's diet?

☐ Very Healthy ☐ Healthy ☐ Average ☐ Needs Improvement ☐ Poor

Has your child's appetite or weight changed lately?____

Has your child had previous trauma?____

___

Has your child been arrested?____

Does your child have an addiction? ☐Yes ☐No

If yes, please explain ____________________________ ___________________________________

Is your child currently on medication? ☐ Yes ☐ No

If so please complete the following:

Medication	Dosage	Physician	Purpose

Does your child have any current medical concerns? ☐Yes ☐No

If yes, please explain ____________________________ ___________________________________

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About Your Child's Education

Age ____ Grade____ Nick Names _________________ Failure or Held Back?_______

Current School____

What do school personnel tell you about your child?___________________________

____

Grade	School	Average Grades	City	State
Pre-K				
K				
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

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11				
12				

About Your Child's Family

Relatives	**Name**	**Age Grade**	**Does the child get along with this person?**	**Occupation**
Father				
Mother				
Sister(s)				
Brother(s)				
Step Mother				
Step Father				
Step Sister(s)				
Step Brother(s)				
Who lives in the child's home?				

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Personal Concerns

What concern has caused you to bring your child into counseling at this time?______________________

____

____

____

How long has this been a concern? ____

In what ways have you attempted to cope?____

____

Has your child been to counseling before? ☐Yes ☐No

If yes, how was your child's previous counseling experience?______________________________

____

Are there any current stressors in the home? (illness, divorce, custody, job loss, addiction, etc.)
☐Yes ☐ No

If yes, please explain: ____

____

____

How does your child handle stress?_________________________ _____________________

Has your child attempted suicide or self-harm in any way? ☐Yes ☐No

If yes, please explain______________________________________ _____________________

____

____

What are your child's strengths?___________________________ ____________________

These Questions are in Regard to Older Children

Is this child in a gang? ☐Yes ☐No

Has this child used drugs? ☐Yes ☐No

If yes, describe which drugs, frequency, age at first use and amounts. _____________________

____

Has this child ever been pregnant or fathered a child? ☐Yes ☐No

If yes, please tell what happened with each pregnancy._________________________________

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Symptom Checklist

Please circle items that apply to your child:

Affectionate	Violent	Hostile	Aggressive
Unhappy	Hitting	Argues	Unmotivated
Cutting	Assaults	Wets Bed	Head Banging
Bossy	Fearful	Hair Pulling	Breaks Law
Negative attitude	Skin Picking	Bullied	Eating Issues
Fire Setting	Cheats	Name Calling	Overactive
Complains of Sick	Mute	Outgoing	Conflicts w/Friends
Lies Often	Provokes Others	Intimidates Others	Disobedient
Rages	Isolates	Talks Back	Sad
Speech Problems	Defiant	Immature	Steals
Lethargic	Shy	Stubborn	Smokes
Runs Away	Destructive	Lacks Respect	Conflict at Home
Likes to be Alone	Slow Responding	Cries Easily	Loss of Friends
Irritable	Intolerable	Disruptive	Conflict at School
Social	Teases	Conflict w/Police	Learning Disability
Moody	Bullies Others	Tantrums	Drug/Alcohol Abuse
Independent	Developmental Delays	Tics, fidgets	Inattentive

Truancy	School Failure	Hyperactive	Nightmares

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Additional Information

Is there anything else you would like me to know about your child?

____
____
____
____
____
____
____
____
____

Mental Status Information

Have you or your child ever – attempted suicide or harmed yourself in any way? ☐Yes ☐No

Are you or your child currently thinking about suicide or harming yourself in any way? ☐Yes ☐No

Have you or your child had any thoughts, even once, in the past, including the past few days or weeks, of suicide or harming yourself in any way? ☐Yes ☐No

Are you or your child having any thoughts about harming anyone else in any way? ☐Yes ☐No

Statement of Understanding

I solemnly swear that all of the above information is true to the best of my knowledge.

____ ________________________
Guardian's Signature Date

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Permission for Professional Services for a Minor:

I have the legal authority to seek and grant permission for professional services for a minor child, there being no legal decree disallowing my authority to assume such responsibility.

____, _______/_______/_______,

Name of Minor Child Date of Birth

____ _____________________________

Parent/Guardian Date