



Confidential Client Intake Form : 13—17years Old (Minor)

*General Information*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sex:  M  F      Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Name of Parents: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Email Address: \_\_\_\_\_ Myspace/Facebook Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation/Title: \_\_\_\_\_

Name of Church/Pastor: \_\_\_\_\_

Please list your brothers and sisters, including step, adopted and foster:

Name	Sex	Age/Year of death	Relationship to you	Describe him/her

*Counseling History*

If you have had any previous counseling, please list the name of the therapists and/or programs:

Name of Therapist/Program	Issues Addressed	Dates in Treatment

*Medical History*

List any physical illnesses or conditions over the last year that might be relevant to you seeking counseling:

\_\_\_\_\_

Please list all current medications you are taking (even if use is seldom or as needed):

Name of Medication	Dosage	Reason for taking medication





## Consent to Treat Teen

Name of minor to be seen \_\_\_\_\_

I agree to avail the above-named minor child into a counseling relationship with the understanding of the following conditions:

- 1) I understand that the minor's counseling records are kept confidential, except where disclosure is required by law (e.g., child abuse/elder abuse reporting requirements, serious threat of harm to self or others) or the minor has signed the appropriate release of information forms.
- 2) Counseling will cover emotional, physical and spiritual aspects of my life and may sometimes be distressing and difficult.
- 3) I have the right to discontinue therapy at any time with minor's consent. I understand terminating counseling is best decided after consulting with minor and minor's therapist.
- 4) I understand that *Life Counseling Center* does not accept insurance for partial or full payment of services rendered. I agree to pay \$\_\_\_\_\_ at the conclusion of each appointment.
- 5) Barring emergencies, I understand I must cancel and/or reschedule minor's appointments by notifying the office **at least 24 hours** prior to the scheduled appointment hour. There will be a **charge** if appointment is cancelled within 24 hours of appointment time. If you do not call and do not show up for your appointment, the **full charge** will apply. In the evenings and on weekends, you may leave a message on our voice mail, which will accurately record the date and time of your call.
- 6) In consideration of the benefits to be derived from the counseling, the receipt whereof is hereby acknowledged, I hereby release, remise and forever discharge and covenant not to sue or hold legally liable *Life Counseling Center*, or employees of the aforesaid from any and all claims, demands, actions or causes of action of whatsoever kind and nature related to the counseling process.

*I have read and understood the preceding information and agree to the policies of Life Counseling Center as stated. I understand that these comments are prerequisite to minor's receiving and continuing counseling through Life Counseling Center.*

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
*Therapist's Signature*

\_\_\_\_\_  
*Date*