NEW EARTH
THERAPY

Clint Intake Questionnaire for Minors

Please complete the following information to the best of your ability. If there is a question that you would prefer not to answer, please leave it blank. If you would prefer to discuss a specific question in person, please indicate so on this form. Please note that the information you provide here is held to the same standards of confidentiality as our therapy.

Personal Information *Date:* _____

First Name: _____ Last Name: _____

Preferred Name: _____

Gender Identity: _____ Preferred Pronoun: _____

Date of Birth: _____ Age:_____

Address: _____

City/Town: _____ Postal Code: _____

Name of School: _____ Grade: _____

Parents/Guardians:

First Name: _____ Last Name: _____

First Name: _____ Last Name: _____

Marital Status: _____

Any special custody arrangements? _____ If yes, describe: _____

Preferred form of communication (email, call, text): _____

Home Phone Number: _____ Can a message be left? _____

Cell Phone Number: _____ Can a message be left? _____

Email: _____

Emergency Contacts

1. Name: _____ Relationship: _____

   Home Phone: _____ Business: _____ Mobile: _____

2. Name: _____ Relationship: _____

   Home Phone: _____ Business: _____ Mobile: _____

How were you referred to my practice? _____

Present Psychological Status

Please states the primary reasons that brings your child to therapy:

_____

_____

How long has this been a problem for your child?

_____

Please describe significant events occurring at the time, or since then, which may relate to the development or maintenance of the presenting concerns:

_____

_____

Please state what you would like us to work on in therapy?

_____

_____

Does your child have any fears or concerns about being in therapy?

_____

_____

What solutions to your child's problems have been most helpful?

_____

_____

Who are the people that you feel provide you and your child with the most emotional support?

_____

_____

Have your child been in therapy before? _____

If yes, when and for what?

_____

_____

Is your child currently engaged in self-harm? _____

Is your child currently contemplating suicide? _____

Has your child recently been diagnosed with a psychological disorder(s)? _____

If yes, please indicate:

_____

_____

Is your child currently taking any prescription psychiatric medication(s)? _____

If yes, please list type and dosage:

_____

_____

Is your child currently using substances (i.e, alcohol, marijuana, caffeine, tobacco, sleeping pills, cocaine, methamphetamines, etc)?

If yes, please describe the amount, frequency and length of time they have been using:

_____

_____

General Health Information

Is there a family history or learning difficulties/disabilities, behavioral and/or mental health issues (circle one)? YES NO

If yes, please describe (include family member and diagnosis):

_____

_____

_____

Please describe your child as an infant (quiet, active, sleep patterns, developmental milestones, temperament, etc):

_____

_____

_____

_____

Please describe your child as a toddler (social, developmentally, sleep, friendships, temperament, etc).

_____

_____

_____

Does your child suffer from any major illnesses or injuring growing up?

_____

_____

_____

Is your child currently experiencing any physical health concerns or medical conditions? If yes, please describe:

_____

_____

_____

When was your child's last physical exam? _____

Family Physician: _____ Office Number: _____

Specialist Physician: _____ Office Number: _____

Other Doctor: _____ Office Number: _____

Alternative Healthcare Practitioner (i.e. Naturopath, Traditional Chinese Medicine):

_____ Office Number: _____

Does your child take any prescription medications? Please describe:

Currently:

Previously:

Does your child take any supplements (i.e., vitamin D, probiotics, etc)? If yes, please list:

_____

_____

Has your child ever experienced a traumatic event? If yes, please describe:

_____

_____

Has your child ever been exposed to abuse (physical, sexual, emotional or physical)? If yes, please explain:

_____

_____

Family Background and Childhood History

Please check any of the following that apply, on behalf of your child:

- ☐ I had very difficult experiences as a child.
- ☐ During my childhood, I experienced a lot of stress.
- ☐ I experienced a traumatic event as a child.
- ☐ I come from a family where my parents were separated or divorced before I was 10 years of age.
- ☐ I have witnessed a traumatic event as a child.
- ☐ I had an impoverished childhood.
- ☐ I had an absent father.
- ☐ I had an absent mother.
- ☐ I was bullied in school.
- ☐ I have been in an abusive relationship.
- ☐ I am currently in an abusive relationship.

Please indicate the parenting style(s) your was exposed to while growing up:

☐ Authoritarian

The parenting style that I was exposed to growing up was such that I received low levels of warmth and responsiveness and high levels of demand and control from my parents. (e.g., parents set strict rules and I had little in the way of expressing opinions/decisions)

☐ Authoritative

The parenting style that I was exposed to growing up was such that I received high levels of warmth and responsiveness and high levels of control from my parents. (e.g., parents set reasonable limits and rules and they showed interest and responded to my needs)

☐ Permissive

The parenting style that I was exposed to growing up was such that I received high levels of warmth and responsiveness, but no set rules or standards. (e.g., I was not responsible for my actions and expressed my opinions/decisions openly)

☐ Neglectful

The parenting style that I was exposed to growing up was such that I received low levels of warmth, responsiveness, and demandingness from my parents. (e.g., parents were not psychologically available and I experienced a significant lack of connection)

Has anyone in your child's family been treated for any of the following?:

	Yes/No	Please indicated family member(s)
Depression		
Anxiety		
Panic Attacks		
Trauma		
Bipolar		
Anorexia/Bulimia		
Obesity		
Schizophrenia		
Substance Abuse		
ADHD		
Suicide Attempts		
Psychiatric Hospital Stay		

Is there any other relevant information about you that you believe is important for me to know?

_____

_____