FaithWorks Counseling, LLC
10505 Wayzata Blvd, #101
Minnetonka, MN 55305
Fx: 952-746-8128

TEEN & CHILD
Registration and Intake Form

Anchor Counseling
110 1st Street E
Jordan, MN 55352
Fx: 952-492-7885

If client is a minor, name of Person Completing Form		Relationship to the minor: [ ] Parent [ ] Foster Parent [ ] Guardian [ ] Other_____
As parent, foster parent or legal guardian I give consent for my child to have therapy at FaithWorks Counseling/Anchor Counseling ***(please sign and date this box)***	Is it OK to call you at the #'s listed below about your account?	Today's Date
Are the parents of the (minor child) client divorced?	If yes – who is the custodial parent?	***If yes – please provide us with a copy of the page(s) of the divorce decree outlining child custodial arrangements.***

Client Information

Client Name (Last - First - Middle) Mr. Dr. Ms. Mrs.	Gender M F	Date of Birth	Social Security No.
Street Address	Home Phone No. ( )		Work Phone No. ( )
City, State, Zip	Employer		Occupation

Name of Guardian ad Litem (if applicable)	Home Phone No. ( )	Work Phone No. ( )
Guardian ad Litem Address	Cell Phone No. ( )	
Who is responsible for this account? (If different than above named Guardian ad Litem or "Self", please list Name/Address/Phone)		
In case of an emergency, please call (Name and phone #)	***Whom May We Thank For Referring You To Us?***	

Insurance Information

We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. **Please give your insurance card to our receptionist to be copied.**

Primary Insurance Carrier	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Street Address	Home Phone No. ( )	Work Phone No. ( )	
City, State, Zip	Employer	Occupation	

Secondary Insurance Carrier (if applicable)	ID #	Group #	Social Security No.
Name of Insured	Relationship to Insured	Date of Birth	Gender M F
Address (Street - City - State - Zip)	Home Phone No. ( )	Work Phone No. ( )	
City, State, Zip	Employer	Occupation	

Initial	Authorization and Release
	I certify the above information is true and correct to the best of my knowledge. I certify that I (or my dependent) have insurance coverage and assign directly to ***FaithWorks Counseling*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand and agree that I am ultimately responsible for payment – and that at this time services rendered ***may not*** be covered by my insurance. I understand that I am financially responsible for all charges whether or not paid by insurance.
	I authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that billing is done by a third-party and that I may contact them with questions regarding my account.
	Statements – will be sent to the address we have listed on file (as provided on this form above). If you wish for your statements to go to an alternate address – you must notify us of this by providing an alternative address when completing this form.

Client / Responsible Party Signature _____ Relationship _____ Date _____

Ethnicity (optional): [ ] Caucasian [ ] African American [ ] Hispanic [ ] Native American [ ] Biracial [ ] Asian [ ] Other:

IMMEDIATE FAMILY

List all persons currently living in child's household:

Name	Age	Sex	Relationship to you

List Children and Stepchildren not living with child:

Name	Age	Sex	Freq. of visits

Intimate relationships of client:
[ ] never been in a serious relationship
[ ] not currently in relationship
[ ] currently in a serious relationship

Relationship satisfaction:
[ ] very satisfied with relationship
[ ] satisfied with relationship
[ ] somewhat satisfied with relationship
[ ] dissatisfied with relationship
[ ] very dissatisfied with relationship

Describe any past or current significant issues in intimate relationships:
_____
_____
_____

MEDICAL HISTORY (check all that apply for client)

Describe current physical health: [ ] Good [ ] Fair [ ] Poor
_____

List name of primary care physician:
Name _____ Phone _____
Fax:_____

List name of psychiatrist: (if any):
Name _____ Phone _____
Fax:_____

List any current medical conditions:_____
_____

List any medications currently being taken (give dosage & reason):
_____
_____
_____

Is there a history of any of the following in the family:

[ ] tuberculosis	[ ] heart disease
[ ] birth defects	[ ] high blood pressure
[ ] emotional problems	[ ] alcoholism
[ ] behavior problems	[ ] drug abuse
[ ] thyroid problems	[ ] diabetes
[ ] cancer	[ ] Alzheimer's disease/dementia
[ ] mental retardation	[ ] stroke

[ ] other chronic or serious health problems _____
_____

Describe any serious hospitalization or accidents:
Date _____ Age _____ Reason _____
_____

[ ] [ ] Prior medication to treat psychological problems? If yes:

No	Yes	Medication	Dosage	Frequency	Start date	End date	Physician	Side effects	Beneficial?

List any known allergies: _____

Which of the following areas of functioning have been impaired?
[ ] Occupational [ ] Academic [ ] Social [ ] Affective (Emotional) [ ] Physical

CURRENT SYMPTOM CHECKLIST (Rate intensity of symptoms present in the last two weeks)
None = This symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning • **Moderate** = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

Symptom	None	Mild	Moderate	Severe		Symptom	None	Mild	Moderate	Severe
Depressed mood						Increased or decreased appetite				
Low energy						Unplanned weight gain				
Sleep disturbances						Unplanned weight loss				
Dissociation						Vandalism				
Hyperactivity						Poor concentration/indecisive				
Bingeing						Purging/over-exercising				
Anger outbursts						Excessive worrying				
Unresolved guilt						Low self-worth				
Irritability						Cruelty to animals				
Nausea/Acid indigestion						Tension				
Social anxiety						Hallucinations				
Self-mutilation/cutting						Racing thoughts				
Impulsive actions/speech						Restlessness				
Nightmares						Loss of interest in normal activity				
Elevated mood						Decreased creativity/productivity				
Losing train of thought						Unresolved anger				
Mood swings						Easily distracted				
Disorganized						Memories of trauma				
Anorexia						Hopelessness				
Social isolation						Parental problems				
Grief						Panic attacks				
Phobia(s)						Suicidal thoughts				
Headaches						Feel panicky/anxious				
Loneliness						Work problems				
Problems at home						Has attempted suicide in the past				
Truancy (skipping school)						Poor grades				
Soiling/Wetting										

Briefly describe how the above symptoms impair your ability to function:_____
_____
_____
_____
_____
_____

(Please do not write here. For therapist's use.)

PRESENTING PROBLEMS

Reasons for seeking therapy:	**How long has this been a problem?**	**Additional information**:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Please do not write here. For therapist's use.)

EMOTIONAL/PSYCHIATRIC HISTORY

Prior outpatient psychotherapy or counseling? [ ] No [ ] Yes If yes, complete the following. List all therapy/counseling:

Age at time	Psychotherapist/Counselor (& Agency, City)	How long?	What were the circumstances?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is child currently seeing any of these? _____

PSYCHIATRIC HOSPITALIZATIONS AND TREATMENT FACILITIES, INCLUDING C.D. TREATMENT

Prior hospitalizations or inpatient treatment for psychological or C.D. issues? [ ] No [ ] Yes If yes, complete:

Age at time	Hospital/Treatment Center	How long?	What were the circumstances?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS DIAGNOSES

Has the child ever been diagnosed with a psychiatric, substance abuse, learning, emotional, or behavioral disorder?

Diagnosis	Age at Diagnosis	Diagnosis was made by:	Agree with diagnosis?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Please do not write here. For therapist's use.)

SUBSTANCE USE HISTORY (check all that apply for client)

Family alcohol/drug abuse history:

[ ] father [ ] stepparent/live-in
[ ] mother [ ] uncle(s)/aunt(s)
[ ] grandparent(s) [ ] spouse/significant other
[ ] sibling(s) [ ] children
[ ] other _____

Substance use status:

[ ] no history of abuse
[ ] active abuse
[ ] early full remission
[ ] early partial remission
[ ] sustained full remission
[ ] sustained partial remission

Substances used: (complete all that apply)

	First use age	Last use age	Current Use (Yes/No)	Frequency	Amount
[ ] alcohol	_____	_____	_____	_____	_____
[ ] amphetamines/speed	_____	_____	_____	_____	_____
[ ] barbiturates/owners	_____	_____	_____	_____	_____
[ ] caffeine	_____	_____	_____	_____	_____
[ ] cocaine	_____	_____	_____	_____	_____
[ ] crack cocaine	_____	_____	_____	_____	_____
[ ] hallucinogens (e.g., LSD)	_____	_____	_____	_____	_____
[ ] heroin	_____	_____	_____	_____	_____
[ ] inhalants (e.g., glue, gas)	_____	_____	_____	_____	_____
[ ] marijuana or hashish	_____	_____	_____	_____	_____
[ ] nicotine/cigarettes	_____	_____	_____	_____	_____
[ ] PCP	_____	_____	_____	_____	_____
[ ] prescription_____	_____	_____	_____	_____	_____
[ ] other_____	_____	_____	_____	_____	_____

Treatment history:

[ ] outpatient (age[s]_____)
[ ] inpatient (age[s]_____)
[ ] 12-step program (age[s]_____)

Consequences of substance abuse (check all that apply):

[ ] hangovers [ ] withdrawal symptoms [ ] sleep disturbance [ ] binges
[ ] seizures [ ] medical conditions [ ] assaults [ ] job loss
[ ] blackouts [ ] tolerance changes [ ] suicidal impulse [ ] arrests

[ ] stopped on own (age[s]_____) [ ] overdose [ ] poor grades [ ] relationship conflicts
[ ] other (age[s]_____ [ ] loss of control amount used other _____
describe:_____

FAMILY OF ORIGIN HISTORY

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
mother	[ ]	[ ]	[ ]
father	[ ]	[ ]	[ ]
stepmother	[ ]	[ ]	[ ]
stepfather	[ ]	[ ]	[ ]
brother(s)	[ ]	[ ]	[ ]
sister(s)	[ ]	[ ]	[ ]
other (specify)	[ ]	[ ]	[ ]

Parents' current marital status:
[ ] married to each other
[ ] separated for _____ years
[ ] divorced for _____ years
[ ] mother remarried __ times
[ ] father remarried ___ times
[ ] mother involved with someone
[ ] father involved with someone
[ ] mother deceased for ___ years
your age at mother's death ____
[ ] father deceased for ___ years
your age at father's death_____

Describe parents:
Father [ ] Biological [ ] Adopt [ ] Step
full name _____
occupation _____
education _____
general health_____
Mother [ ] Biological [ ] Adopt [ ] Step
full name _____
occupation _____
education _____
general health_____

Describe the child's family experience:
[ ] outstanding home environment [ ] normal home environment [ ] chaotic home environment [ ] alcoholic/addicted parent(s)
[ ] witnessed or was aware of physical/verbal/sexual abuse (circle all that apply) [ ] poverty (serious financial problems)
[ ] experienced physical/verbal/sexual abuse from others (circle all that apply)

Describe any abuse the child has experienced:

Other difficult experiences the child has had:

Age of emancipation from home: _____ Circumstances:

Describe any past or current significant issues in other <u>immediate family</u> relationships:

Has any family member ever received a psychiatric diagnosis, or psychological treatment, either inpatient or outpatient (therapy)? Has any family member ever taken medication for a psychological problem? Please describe: _____

(Please do not write here. For therapist's use.)

DEVELOPMENTAL HISTORY (Check all that apply to client development. If you do not know, write DK.)

Problems during mother's pregnancy:
[ ] none
[ ] high blood pressure
[ ] bed rest
[ ] alcohol use
[ ] drug use
[ ] cigarette use
[ ] other

Birth:
[ ] normal delivery
[ ] difficult delivery
[ ] cesarean delivery
[ ] complications _____
_____
birth weight __lbs __oz.

Infancy:
[ ] feeding problems
[ ] sleep problems
[ ] toilet training problems
[ ] colic

Childhood health:
[ ] lead poisoning (age ____)
[ ] head injury (list age and describe)_____
_____
[ ] other significant injury (list age and describe)_____
_____
[ ] asthma (age diagnosed_____)
[ ] seizures (type and ages)_____
[ ] ear infections
[ ] hearing loss (age diagnosed & severity)_____
[ ] impaired vision not corrected by lenses (ages_____)
[ ] surgeries (ages and type)_____
[ ] chronic, serious health problems _____
_____

Delayed developmental milestones (check only those milestones that were not reach at expected age):

[ ] sitting
[ ] rolling over
[ ] standing
[ ] walking
[ ] engaging peers
[ ] tolerating separation
[ ] toilet training
[ ] riding bicycle

Emotional / behavior problems (check all that apply to the child):

[ ] drug use
[ ] alcohol abuse
[ ] stealing
[ ] often sad
[ ] violent temper
[ ] distrustful
[ ] hostile/angry
[ ] impulsive
[ ] indecisive
[ ] immature
[ ] extreme worrier
[ ] self-injurious acts
[ ] fire-setting
[ ] anxious
[ ] easily distracted

[ ] speaking [ ] disobedient [ ] hyperactive [ ] frequently daydreamed

Social interaction (check all that apply to the child):
[ ] normal social interaction [ ] inappropriate sex play
[ ] isolated self [ ] dominated others
[ ] very shy [ ] had acting out friends
[ ] other _____

Intellectual / academic functioning (check all that apply to the child:
[ ] normal intelligence [ ] authority conflicts [ ] mild retardation
[ ] high intelligence [ ] attention problems
[ ] moderate retardation
[ ] special education from _____ to____ for_____
Current or highest education level _____

Describe any other developmental problems or issues:

_____
_____
_____
_____

SOCIO-ECONOMIC HISTORY (check all that apply for client)

Living situation:
[ ] housing adequate
[ ] homeless
[ ] housing overcrowded
[ ] dependent on others for housing
[ ] housing dangerous/deteriorating

Social support system:
[ ] supportive network
[ ] few friends
[ ] substance-use-based friends
[ ] no friends
[ ] distant from family of origin
[ ] living companions dysfunctional

Sexual history:
[ ] heterosexual orientation [ ] currently sexually dissatisfied
[ ] homosexual orientation [ ] age first sex experience ____
[ ] bisexual orientation [ ] age first pregnancy/fatherhood
[ ] currently sexually active [ ] history of promiscuity ages:
[ ] history of unsafe sex: ages ____ to ____
ages ____ to ____

Employment:
[ ] employed and satisfied
[ ] employed but dissatisfied
[ ] unemployed
[ ] coworker conflicts
[ ] supervisor conflicts
[ ] change jobs a lot
[ ] disabled: _____

Financial situation:
[ ] no current financial problems
[ ] large indebtedness
[ ] poverty
[ ] impulsive spending
[ ] relationship conflicts over finances

Legal history:
[ ] no legal problems
[ ] now on parole/probation
[ ] arrest(s) not substance-related
[ ] arrest(s) substance-related
[ ] court ordered this treatment
[ ] jail/prison _____ time(s)
total time served:_____
describe last legal difficulty: ____
_____

Cultural/spiritual/recreational history:
cultural identity (e.g., ethnicity, religion): _____
_____
describe any cultural issues that contribute to current problem:
_____
active in community/recreational activities? Yes [ ] No [ ]
was active in community/recreational activities? Yes [ ] No [ ]
currently engage in hobbies? Yes [ ] No [ ]
currently participate in spiritual activities? Yes [ ] No [ ]
if answered "yes" to any of above, describe: _____
_____
_____
Name and City of church attended:
_____

ENVIRONMENTAL STRESSORS (Check all that apply for client and are current or recent)

___ Death of a family member
___ Health problems in family
___ Disruption of family by separation
___ Disruption of family by divorce
___ Disruption of family by estrangement
___ Marital stress
___ Removal from the home
___ Remarriage of parent
___ Sexual abuse
___ Physical abuse
___ Parental overprotection
___ Neglect of a child
___ Inadequate discipline
___ Discord with siblings
___ Birth of a sibling
___ Birth of a child
___ Death or loss of a friend
___ Inadequate social support
___ Living alone
___ Difficulty with acculturation
___ Discrimination
___ Adjustment to life cycle transition
___ Illiteracy

___ Academic problems
___ Discord with teachers or classmates
___ Unemployment
___ Threat of job loss
___ Stressful work schedule
___ Job dissatisfaction
___ Job change
___ Discord with boss or coworkers
___ Homelessness
___ Inadequate housing
___ Unsafe neighborhood
___ Discord with neighbors or landlord
___ Extreme poverty
___ Inadequate finances
___ Insufficient welfare support
___ Inadequate healthcare
___ Inadequate health insurance
___ Recent arrest or incarceration

___ Involved in litigation
___ Victim of a recent crime
___ Exposure to war, disasters or other hostilities
___ Discord with counselor, social worker, physician or other
___ Other _____

CURRENT LEVEL OF FUNCTIONING (GAF)

For therapist use only	**Please check one of the statements below:**
___ 100	___ No symptoms.
___ 90	___ Minimal symptoms. (e.g. "everyday worries", occasional blow-up with peers, siblings or parents)
___ 80	___ Occasional symptoms. (e.g. some disturbance of behavior, blow-ups are more frequent, but disturbance is minimal)
___ 70	___ Mild symptoms. (e.g. occasionally truant, petty theft, falling behind in schoolwork)
___ 60	___ Moderate symptoms. (e.g. missing school, disturbances in at least several but not all areas of functioning)
___ 50	___ Serious symptoms. (e.g. suicidal preoccupation, some aggressive behavior, obsessive rituals, school refusal)
___ 40	___ Severe symptoms. (e.g. persistent aggression, suicidal attempts with clear lethal intent, withdrawn and isolated)
___ 30	___ Extreme symptoms. (e.g. delusional, incoherent, acts grossly inappropriate, stays in bed all day)
___ 20	___ Catastrophic symptoms. (e.g. needs considerable supervision to prevent hurting self and others)
___ 10	___ Symptoms require 24—hr. care (e.g. grossly impaired in all areas of functioning)

Client/Family has been informed of assessment summary: [ ] Yes [ ] No

Based upon the information obtained during this initial assessment, it is recommended that this client:

___ A. Not be accepted as an Appropriate Client for FaithWorks Counseling/Anchor Counseling.
___ B. Be accepted as an Appropriate Client for FaithWorks Counseling/Anchor Counseling.

I have reviewed the Assessment & Diagnosis:

Intake Therapist's Signature: _____ Date: _____

Supervisor (If Appropriate): _____ Date: _____