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# BURKE COUNSELING, PLLC

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## Intake Information for a **Minor**

The following information will be kept confidential.

### GENERAL INFORMATION

Today's date \_\_\_\_\_ Child's Birthdate \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Other # \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

Place of Employment \_\_\_\_\_ # of hours per week \_\_\_\_\_

### PRESENTING PROBLEM

Briefly describe your child's current difficulties: \_\_\_\_\_

How long has this problem been of concern to you? \_\_\_\_\_

When was the problem first noticed? \_\_\_\_\_

What seems to help the problem? \_\_\_\_\_

What seems to make the problem worse? \_\_\_\_\_

Has the child received evaluation or treatment for the current problem in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when and with whom? \_\_\_\_\_

What do you hope/expect to get from this counseling experience? \_\_\_\_\_

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**HEALTH INFORMATION**

Please rate your child's physical health: Very good \_\_\_\_\_ Good \_\_\_\_\_ Average \_\_\_\_\_ Declining \_\_\_\_\_

Recent weight changes: Lost \_\_\_\_\_ Gained \_\_\_\_\_

List important present or past illnesses or injuries: \_\_\_\_\_

Physician's name: \_\_\_\_\_ Date of last exam? \_\_\_\_\_

Is the child on any medication at this time? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please note kind of medication: \_\_\_\_\_

For what reason is your child taking the medication? \_\_\_\_\_

Has your child been treated by a psychiatrist? Yes \_\_\_\_\_ No \_\_\_\_\_ Date of treatment? \_\_\_\_\_

For how long? \_\_\_\_\_

Name of psychiatrist, if applicable: \_\_\_\_\_

What disciplinary techniques do you usually use when your child behaves inappropriately? Place a check next to each technique that you usually use. There also is space for writing in any other disciplinary techniques that you use

- |                                        |                                  |
|----------------------------------------|----------------------------------|
| _____ Ignore problem behavior          | _____ Tell child to sit on chair |
| _____ Scold child                      | _____ Send child to his/her room |
| _____ Spank child                      | _____ Take away some activity    |
| _____ Threaten child                   | _____ Take away food             |
| _____ Don't use any technique          | _____ Reason with child          |
| _____ Other technique (describe) _____ |                                  |

Which disciplinary techniques are usually effective? \_\_\_\_\_

\_\_\_\_\_

Which disciplinary techniques are usually ineffective? \_\_\_\_\_

\_\_\_\_\_

What have you found to be most satisfactory ways of helping your child? \_\_\_\_\_

\_\_\_\_\_

What are your child's assets or strengths? \_\_\_\_\_

\_\_\_\_\_

Is there any other information that you think may help in working with your child? \_\_\_\_\_

\_\_\_\_\_

### **SPIRITUAL INFORMATION**

Currently attend/member of a church? \_\_\_\_\_ Which one? \_\_\_\_\_

How long? \_\_\_\_\_ Times per month attending \_\_\_\_\_

Religious background of family? \_\_\_\_\_

Does family attend with child? \_\_\_\_\_ Other religious background \_\_\_\_\_

### **EMOTIONAL INFORMATION**

Have you ever had a severe emotional upset? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain: \_\_\_\_\_

\_\_\_\_\_

Have you ever had counseling in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list counselor or therapist and dates: \_\_\_\_\_

\_\_\_\_\_

What was the outcome? \_\_\_\_\_

\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Place a check next to any illness or condition that any member of the immediate family has had. When you check an item, please note the member's relationship to the child.

(√) Condition	Relationship to child	(√) Condition	Relationship to child
___ Alcoholism	_____	___ Cancer	_____
___ Diabetes	_____	___ Heart trouble	_____
___ Depression	_____	___ Suicide attempt	_____
___ Nervous or psychological	_____	___ Other	_____

**EDUCATION INFORMATION**

Current School: \_\_\_\_\_ Phone #: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Is your child receiving special education services? Yes \_\_\_ No \_\_\_ If yes, what type of services?

\_\_\_\_\_

Has your child been held back in a grade? Yes \_\_\_ No \_\_\_ If yes, what grade and why? \_\_\_\_\_

\_\_\_\_\_

Has your child ever received special tutoring or therapy in school? Yes \_\_\_ No \_\_\_

If yes, please describe: \_\_\_\_\_

Place a check (√) next to any educational problem that you child currently exhibits.

___ Has difficulty with reading	___ Has difficulty with arithmetic
___ Has difficulty with spelling	___ Has difficulty with writing
___ Does not like school	___ Has received detentions in this past year
___ Skips school / classes	___ Has been suspended or expelled this past year
___ Has difficulty with other subjects (please list) _____	

What are your child's favorite activities? 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

What activities would your child like to engage in more often than he/she does at present?

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**OTHER INFORMATION**

What activities does your child like least? 1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_

Has your child ever been in trouble with the law? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please describe briefly \_\_\_\_\_

Circle the following word(s) which best describe your child now:

- |            |                |            |             |                |            |
|------------|----------------|------------|-------------|----------------|------------|
| active     | impatient      | calm       | extravert   | lonely         | ambitious  |
| impulsive  | serious        | likable    | sensitive   | self-confident | persistent |
| moody      | often blue     | easy-going | shy         | leader         | quiet      |
| nervous    | hardworking    | excitable  | imaginative | good-natured   | introvert  |
| submissive | self-conscious | depressed  |             |                |            |

other: \_\_\_\_\_

Does your child see or hear things that don't exist? \_\_\_\_\_

Does your child have problems sleeping? \_\_\_\_\_

Has your child talked about or attempted suicide? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

**CURRENT FAMILY INFORMATION**

Mother's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current address: \_\_\_\_\_

Age: \_\_\_\_\_ Education: \_\_\_\_\_

Father's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current address: \_\_\_\_\_

Age: \_\_\_\_\_ Education: \_\_\_\_\_

Step-mother's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current address: \_\_\_\_\_

Age: \_\_\_\_\_ Education: \_\_\_\_\_

Step-father's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Current address: \_\_\_\_\_

Age: \_\_\_\_\_ Education: \_\_\_\_\_

List all others currently living in the household:

Name	Relationship to Child	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____

If any brothers or sisters are living outside the home, list their names and ages:

\_\_\_\_\_

\_\_\_\_\_