

MINNESOTA RENEWAL CENTER

Child Registration Intake Form

3499 Lexington Avenue N #100, St Paul, MN 55126

Phone: 651-486-4828

INSTRUCTIONS: Thank you in advance for completing this form. The information you provide will help me to better understand your child's needs and those of your family. Please complete ALL information by printing clearly. Thank you.

Today's Date: _____

Child/Adolescent Name: _____ Sex: __F __M Grade in School: _____
Name of School: _____

Age: ____ Date of Birth: _____

Address: _____

City: _____ State: ____ Zip: _____

If not client, name of individual filling out form: _____

Relationship to client: _____

May I leave a message at your home phone? Yes or No (circle one) Home Phone: _____

May I leave a message at your work phone? Yes or No (circle one) Work Phone: _____

May I leave a message at your mobile phone? Yes or No (circle one) Mobile Phone: _____

Work Hours/Best Time to Call: _____

Email: _____

How were you referred to me? _____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy for your child today?

2. Did a specific event lead to this request for service? Yes No If yes, please describe the incident. _____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy. _____

4. How long has the problem been present? _____

5. What solutions to the problem have you tried, and what were the results? _____

6. How much does this problem affect your child's life? (Please circle the number that best applies)

	Not at all	A Little bit	A lot	All the time
1. Personally	1	2	3	4
2. Family life	1	2	3	4
3. Socially	1	2	3	4
4. Work	1	2	3	4
5. Academically	1	2	3	4

7. Do you make use of any community-based support groups (e.g. 12-Step Programs, social support groups, etc)? Yes No If yes, please specify: _____

8. Do you have an involvement with any of the following people or services? Yes No If yes, please circle all that apply:
 Mediation County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litum

Symptoms

9. Please look these items over and circle the number that best describes how these symptoms have bothered your child recently.

	Not at all	Mildly	Moderately	Severely
1. Depressed, sad, or crying	1	2	3	4
2. Guilty feelings	1	2	3	4
3. Suicidal thoughts, plans, or attempt	1	2	3	4
4. Changed sleep patterns	1	2	3	4
5. Change in weight or eating habits <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
6. Loss of interest or energy	1	2	3	4
7. Anxious, nervous, or panicky feelings	1	2	3	4
8. "Avoiding places" or situation	1	2	3	4
9. Repetitive thoughts or behaviors	1	2	3	4
10. Change in school performance <input type="checkbox"/> Increase <input type="checkbox"/> Decrease	1	2	3	4
11. Anger or temper problems	1	2	3	4
12. Physical problems, pain, or illness	1	2	3	4
13. Sexual worries or problems	1	2	3	4
14. Spending habits	1	2	3	4
15. Memory problems	1	2	3	4
16. Confused, disorganized	1	2	3	4
17. Hallucinations	1	2	3	4
18. Difficulty paying attention	1	2	3	4
19. Difficulty sitting still/being quiet or listening	1	2	3	4
20. Regression (previously toilet trained, bed wetting)	1	2	3	4

Mental Health History

10. Please describe any previous counseling or therapy your child has had (or is currently involved in).

11. Has your child engaged in self-harming behaviors such as cutting or suicide attempts?

Yes No

If yes, what behavior, how many times, and when? _____

12. If applicable, please describe any previous psychiatric hospitalizations and about when they occurred.

13. Is your child currently taking any medications to treat , anxiety, ADHD, or other mental health issues?

Yes No If yes, please list:

Medication _____ Dosage _____ Number of pills per day _____

Medication _____ Dosage _____ Number of pills per day _____

Medication _____ Dosage _____ Number of pills per day _____

Medical History

14. Were there any difficulties or complications during your child's birth?

15. List any significant health problems, past or present, including surgeries and/or illnesses with the *corresponding dates*.

16. Is your child currently taking any other medications? Yes No If yes, please list:

Medication/Reason	Dose and number of pills you take per day (e.g. .25 mg. 3 times per day)	Prescribing doctor

17. Does your child have any medical or physical conditions that would interfere with their treatment here (circle one)?

Yes No If yes, please explain

Family Information (for Parents)

18. What is your marital status? (Please circle all that apply)

Single Married Cohabiting Divorced Widowed Engaged
 Separated Remarried

19. If you are married, how long have you been married? _____
Has there ever been a parental separation? _____ If yes, for how long? _____

20. Current Household Composition and Immediate Family.

Name	Age	Relation to Child	Occupation/School	In Home?

If the child lives part of the time in a different household, please describe the living arrangements (i.e. weekends with father, etc) _____

Employment/Education Information (for Parents)

21. Are you employed? _____
22. Occupation/type of work? _____
23. Are you a student? _____ Full Time or Part Time? _____
24. Are you retired? _____
25. The highest level of education that you have completed (circle one):

Some high school Completed high school Some college/Technical
Completed college Some graduate work Graduate degree or higher

Resources

26. Do you have any spiritual beliefs or practices that are important to you? Yes No If yes, please explain: _____

27. What aspects of your child’s culture, heritage, or ethnicity would you like your therapist to be aware of? _____
