ROOTED WINGS, LLC
Stacey L. Jackson, LPC

2375 E. Main Street
Suite A-105
Spartanburg, SC 29307-1400
864-398-9322
888-707-1002
sljacksonlpc@gmail.com
staceyljacksonlpc.weebly.com

INTAKE - MINOR

Client Information

1. **Please enter your information.**

First Name | Middle Initial | Last Name | Date of Birth

Address | Apt./Unit #

Social Security Number | Gender ○ Female ○ Male

Student Status ○ Full-time ○ Part-time ○ NA | Name of Current School | Current Grade in School | Highest Grade/Degree Completed

How Did You Hear About My Practice?
☐ Former/Current Client ☐ Website ☐ Internet Search ☐ Healthcare Professional
☐ Mental Health Provider ☐ Insurance Company ☐ Word of Mouth ☐ Other

Primary Insurance Company | Primary Insurance Policyholder | Primary Ins Policyholder's DOB

Primary Insurance ID# | Primary Insurance Group# | Client Relationship to Insured

Secondary Insurance Company | Secondary Insurance Policyholder | Secondary Ins Policyholder's DOB

Secondary Insurance ID# | Secondary Insurance Group# | Client Relationship to Insured

Responsible Party Name | Responsible Party Relationship to Client

Responsible Party Address

Resp Party Cell Phone | Resp Party Home Phone | Emergency Contact Name

Emergency Contact Relationship to Client | Emergency Contact Phone#

Emergency Contact Address

Communication Preferences

2. Parent with Primary (Physical) Custody

Cell Phone

Okay to leave message on cell phone? ○ Yes ○ No

Okay to send texts to cell phone? ○ Yes ○ No

Home Phone

Okay to leave message on home phone? ○ Yes ○ No

Work Phone

Okay to leave message on work phone? ○ Yes ○ No

E-mail

Okay to send email reminders? ○ Yes ○ No

3. Co-Parent

Cell Phone

Okay to leave message on cell phone? ○ Yes ○ No

Okay to send texts to cell phone? ○ Yes ○ No

Home Phone

Okay to leave message on home phone? ○ Yes ○ No

Work Phone

Okay to leave message on work phone? ○ Yes ○ No

E-mail

Okay to send email reminders? ○ Yes ○ No

Therapy/Counseling History

4. Please enter your therapy/counseling information.

What brings you to therapy/counseling at this time?

What would you like to accomplish in therapy/counseling?

Has minor received therapy/counseling services before?
○ Yes ○ No

If yes, please describe when/where/reason

Is the minor currently, or has the minor previously been, under the care of a psychiatrist?
○ No ○ Yes

Psychiatrist Phone#

Has minor ever been hospitalized for mental health issue?
○ Yes ○ No

If yes, please describe when/where/reason

Does the minor currently have, or has the minor previously had, a mental health diagnosis? If yes, please specify

Is there a family mental health history including suicide?
○ Yes ○ No

If yes, specify who and diagnosis/type of mental health issue

Medical Information

5. Please enter your medical information.

Primary Care Physician

Primary Care Physician Phone#

Please list any medical problems

Please list current medications including name of medication, dosage, how taken, and what prescribed for

Family History

6. Please provide the minor's family information.

Important individuals present during minor's childhood & adolescence (check all that apply)
☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent(s) ☐ Sister(s) ☐ Brother(s) ☐ Aunt(s) ☐ Uncle(s) ☐ Other

Please list the birth order for the minor and his/her siblings

Parents current marital status
☐ Married to each other ☐ Separated ☐ Divorced ☐ Mother remarried ☐ Father remarried ☐ Mother involved w/ someone ☐ Father involved w/ someone

Mother living?
○ Yes ○ No

Minor's age at Mom's death

Father living?
○ Yes ○ No

Minor's age at Dad's death

How would you characterize the minor family's socioeconomic status?
○ Wealthy ○ Poor ○ Upper Middle Class ○ Middle Class ○ Lower Middle Class

How would you describe the minor's childhood experience (check all that apply)
☐ Loving/Supportive ☐ Stable ☐ Little memory of it ☐ Verbally abusive ☐ Emotionally abusive
☐ Physically abusive ☐ Conditional ☐ Chaotic ☐ Unstable ☐ Parents argued ☐ Domestic violence
☐ Other

Briefly describe current living situation (primary home, secondary home, both, etc.)

Who lives in the home with the minor?

Trauma/Abuse History

7. Please enter the minor's trauma/abuse information.

Has the minor ever been abused?
○ Yes ○ No

If yes, specify type (check all that apply)
☐ Physical ☐ Sexual ☐ Emotional ☐ Verbal ☐ Neglect
☐ Crime Victim ☐ Homelessness ☐ Financial problems

Has the minor ever experienced any of these other traumas? (check all that apply)
☐ Parent substance abuse ☐ Teen pregnancy ☐ Parent illness ☐ Lived in foster home
☐ Multiple family moves ☐ Violence in home ☐ Abandoned by parent
☐ Non-custodial Parent lack of involvement ☐ Lived in group home

Any major losses/separations from family members or significant persons?
○ Yes ○ No

If yes, please describe

Other traumas? Please specify what and when it occurred.

Substance Use History

8. Please enter your substance use/history information.

Does the minor currently use any of these substances?
☐ Alcohol ☐ Marijuana ☐ Inhalants ☐ Steroids
☐ Caffeine
☐ Sedatives (Benzodiazepines, Barbituates)
☐ Stimulants (Crack, Cocaine, Methamphetamines, Speed)
☐ Hallucinogens (LSD, Mushrooms, Mescaline)
☐ Opiates (Heroine, Codeine, Morphine) ☐ Nicotine
☐ Other

If currently using substance(s), please specify how much, how often, and date of last use

If not currently using substance(s), did the minor previously do so? If yes, please describe the prior substance use

Does anyone in the minor's family have a substance abuse problem?
○ Yes ○ No

If yes, please specify who and substance used

Interpersonal/Social/Cultural Information

9. **Please enter minor's information.**

Describe minor's strengths, skills, talents

Please describe the minor's social support network (check all that apply)
☐ No friends ☐ Few friends ☐ Family ☐ Neighbors ☐ Co-workers ☐ Support/Self-help Group
☐ Religious/Spiritual center ☐ Community group

Is the minor experiencing any difficulties due to cultural/ethnic issues? If yes, please describe

Describe minor's areas of special interests, hobbies, etc.

Please describe activities that the minor is involved in

Religious upbringing?
○ Yes ○ No

Affiliation

Would you like spiritual/religious beliefs to be incorporated into your counseling?
○ Yes ○ No

Please describe any additional information that you feel important for the counselor to know