



of Mooresville

Professional Counseling for the Whole Person from a Christian Perspective

222 Southside Avenue · Mooresville, NC 28115

704-658-0238 · 704-658-0896 FAX

www.CCofMooresville.com

MINOR INTAKE FORM

Name _____ Date of Birth: _____

Address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell: _____

Parent's Work Phone: _____ Which of these is the best way to reach you? _____

Email Address: _____

Parent's email address: _____

Are your parents divorced? _____ How old were you? _____ Did they remarry? _____

Do you have any siblings? _____ If so, how many? _____ Where are you in the birth order? _____

Do you have a good support system? _____ Is your family part of your support system? _____

Please give the following information for each person that currently lives in your home, **including yourself**.

Name	Age	Relationship to Self
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please also list any other people in your immediate family who may not be living in your house:

Name	Age	Relationship to Self
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal and Medical Information:

Are you currently taking any prescription medications? _____ Name of Medication _____

List any past or present medical issues: _____

List any secondary issues, (sleeplessness, constant worry, phobias): _____

Date of Last Physical: _____



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Continued (Minor Intake Form)

Note any significant events occurring at this time (trouble in school, death in family, divorce of parents):

List any emotional issues that are present (anger, anxiety, moodiness):

Have you had thoughts of harming yourself or ending your life?
If yes, please describe (how long ago?; did you have a plan?):

Have you had thoughts of harming someone else? Him Her If yes, please explain:

Family History (please include yourself in this and specify whom it is in your family):

Alcoholism/Drug Abuse:
Depression, Manic/Depression, Schizophrenia:
Other mental illness:
Emotional, verbal, physical, or sexual abuse:
Other significant childhood traumas:

Background Information:

Where do you go to school?
Do you currently attend church? If yes, which church?
Are you in youth group? If yes, which church?
Are your parents living? Him Her
Parents' Occupation? Father: Mother:
Have you ever seen a therapist before? If yes, was it helpful and how?
What brings you here today?

FOR OFFICE USE ONLY

Counselor: Diagnosis:

A-U-F-P-B-C: Length of Visit: 1/2 Hr. Hr. Hr. & 1/2 2 Hrs.