



THE
Relationship
INSTITUTE
Counseling. Coaching. Consulting.

Email: info@tri-la.org | Website: tri-la.org | Phone: 225.300.8484 | Fax: 225.300.8482

Youth Intake Form

Please complete this form in its entirety and bring it with you to your 1st appointment.

PERSONAL INFORMATION		
Name	Date of Birth	Gender M F
Address	City/Zip	
School	Grade	

FAMILY INFORMATION		
Mother's Name	Phone Number ()	
Father's Name	Phone Number ()	
Email	Email Appointment Reminders?	Y N
	Text Appointment Reminders?	Y N
Emergency Contact	Emergency Phone ()	
Who does child live with?		

How did you hear about The Relationship Institute? _____

_____ Private Pay _____ Insurance

REQUIRED INSURANCE INFORMATION	
Name of Insurance Carrier _____	Member ID # _____
Policyholder's Name _____	Policy holder's DOB _____
Name of Employer _____	Group Number _____
<p>Please note: You are required to verify your benefits before attending your first appointment. Our office will not know your exact benefits & coverage until we receive an explanation of benefits from your insurance company after the first billing.</p>	

Family Information
Explain your child's living arrangements, custody issues, and important people in their lives.
Sibling(s) names and age(s)
Who are the other important people in your child's life that they depend on for emotional support? (include friends, family members, religious organizations, clubs etc.)

Answer the following			
Does your child drink alcohol or use illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever been arrested or incarcerated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child currently have outstanding legal charges or court dates?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is anyone requiring your child to attend counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever been physically, emotionally, or sexually abused?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mental Health History		
Has your child ever received a mental health diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis Physician Name Year
Has your child ever attended counseling before today?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Therapist name Dates Outcome: <input type="checkbox"/> Successful <input type="checkbox"/> No Change <input type="checkbox"/> Worst
Does your child currently see a psychiatrist or professional who prescribes medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physician name:
Has your child ever had a psychiatric or psychological evaluation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason Physician Name Year
Has your child ever been hospitalized for a psychiatric condition, drug or alcohol abuse, an eating disorder, self-injurious behaviors, or suicidal ideation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason Name of Facility Date(s)
Do you have any close relatives (parents, siblings, grandparents) who have experienced a mental health condition including	<input type="checkbox"/> Yes <input type="checkbox"/> No	List relationship and diagnosis

depression, anxiety, bi-polar disorder, OCD & Schizophrenia?		
Do any close relatives (parents, siblings, grandparents) have or have had drug or alcohol abuse problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	List relationship and substance(s) used

Parental Concerns Checklist

Please read this list and check all issues that concern you about your child.

<input type="checkbox"/> Abuse/ Neglect	<input type="checkbox"/> Grief/loss	<input type="checkbox"/> Oppositional Behavior
<input type="checkbox"/> Academic Problems	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Panic Attacks
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Harms animals	<input type="checkbox"/> Parent Child Conflict
<input type="checkbox"/> Aggressive Behavior	<input type="checkbox"/> Hates being alone	<input type="checkbox"/> Peer Conflict
<input type="checkbox"/> Alcohol/Drug Use	<input type="checkbox"/> Headaches	<input type="checkbox"/> Phobias
<input type="checkbox"/> Anger Problems	<input type="checkbox"/> Homicidal Thoughts	<input type="checkbox"/> Poor attention/concentration
<input type="checkbox"/> Anxious or Nervousness	<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Restlessness/on edge
<input type="checkbox"/> Appetite Problems	<input type="checkbox"/> Hostile	<input type="checkbox"/> Risk Taking Behaviors
<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Runs away
<input type="checkbox"/> Blended Family Issues	<input type="checkbox"/> Immature for age	<input type="checkbox"/> Self-centered
<input type="checkbox"/> Can't Say No	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Self-destructive
<input type="checkbox"/> Behavior at School	<input type="checkbox"/> Isolation from others	<input type="checkbox"/> Self-Injury/cutting
<input type="checkbox"/> Cries Often	<input type="checkbox"/> Hypersensitive	<input type="checkbox"/> Separation Issues
<input type="checkbox"/> Damages Property	<input type="checkbox"/> Lack of Friends/ Loneliness	<input type="checkbox"/> Serious illness/injury
<input type="checkbox"/> Depression	<input type="checkbox"/> Lack of Motivation	<input type="checkbox"/> Sexually Acting Out
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Legal Problems	<input type="checkbox"/> Sexual Orientation Issues
<input type="checkbox"/> Difficulty Making Decisions	<input type="checkbox"/> Loss of interest in activities	<input type="checkbox"/> Shyness
<input type="checkbox"/> Distrustful/Guarded	<input type="checkbox"/> Low Self Esteem	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Domestic Violence in Home	<input type="checkbox"/> Lying or stealing	<input type="checkbox"/> Social Anxiety



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<input type="checkbox"/> Divorce – problems with	<input type="checkbox"/> Manipulative	<input type="checkbox"/> Suicidal Thoughts
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Major life Change	<input type="checkbox"/> Suicide Attempts
<input type="checkbox"/> Experienced Trauma	<input type="checkbox"/> Mean to Others	<input type="checkbox"/> Tired all of the time
<input type="checkbox"/> Fighting	<input type="checkbox"/> Memory Problems	<input type="checkbox"/> Truancy
<input type="checkbox"/> Fire Setting	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Victim of Bullying
<input type="checkbox"/> Fearlessness	<input type="checkbox"/> OCD behaviors	<input type="checkbox"/> Victim of Rape
<input type="checkbox"/> Fatigue/low energy	<input type="checkbox"/> Negative thoughts/outlook	<input type="checkbox"/> Weight Gain/Loss
<input type="checkbox"/> Flashbacks	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Withdrawn

NOTES: _____

Guardian Signature _____ Date _____