



WHOLE HEART
COUNSELING

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Child Intake form

Name _____

Age _____ Birthdate _____ Gender _____ (

Child's school & grade _____

Referred by _____

Best Phone Number(s) to be reached at _____

Address(es) _____

Email _____

Biological Mother _____ Age _____

Occupation _____

Biological Father _____ Age _____

Occupation _____

Guardian _____ Age _____

Occupation _____

Step or co-parents involved in child's life _____

1. Please describe the main concerns that prompted you to seek counseling for your child/adolescent? _____

2. Please indicate what major stressors the youth has had in the last 12 months (*i.e. divorce/separation, social changes, new school, diagnosis, serious illness, injury, death of a close friend or family member, major illness in the family, gain of a new family member, other*)

3. What you would like to be different when therapy ends?

4. Has the youth ever received psychological or psychiatric counseling before?

Yes ___ No ___ if yes, please describe when, from whom, purpose and results

5. Has the youth ever been prescribed medication for psychiatric or emotional problems?

Yes ___ No ___ if yes, please describe when, prescribing clinician, what medication, for what, and the results

5. Violent behaviors _____

6. Mental Illness of Family Member _____

7. Spiritual Resources

How significant a role does spirituality play in the families'/child's life?

None ____ Somewhat important _____ Significant _____ Very Significant _____

8. Early Childhood

What was first 2 years like for your child? Were there any major occurrences, transitions, difficult pregnancy or delivery, post partum, etc.? What was your child's temperament at this age? Also, did they have any physical challenges?

9. Other

Is there anything else you think I should know about prior to beginning counseling with the child?

Form Completed By: _____ Date: _____

Parent/Guardian Signature:
