CLIENT INTAKE FORM - MINOR

Under the age of 18

GROFF & ASSOCIATES
lighting the way

Child's Information - Please print clearly - *One person per section.*

Today's Date: ____ /____/ ____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ - _____ Gender: ☐ Male ☐ Female

Cell Phone: ( ) _____ - _____ Child's Birth Date: _____ / _____ / _____

Referred By: _____ Clinician's Name: _____

Email Address: _____

Child's Mother - Please print clearly. ☐ Responsible Party ☐ Insurance Policy Holder

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ - _____ Mother's Birth Date: _____ / _____ / _____

Cell Phone: ( ) _____ - _____ Referred By: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Other Employer's Name: _____

May we leave messages identifying our agency?

Yes ☐ at home ☐ on cell phone OR No ☐ please don't leave messages

Child's Father - Please print clearly. ☐ Responsible Party ☐ Insurance Policy Holder

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Home Phone: ( ) _____ - _____ Father's Birth Date: _____ / _____ / _____

Cell Phone: ( ) _____ - _____ Referred By: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Other Employer's Name: _____

May we leave messages identifying our agency?

Yes ☐ at home ☐ on cell phone OR No ☐ please don't leave messages

NOTE: If insurance is filed by Groff & Associates, all **standard billing rates** must apply. If you are paying a reduced rate and try to file an insurance claim on your own, it constitutes *insurance fraud* and we will not release the information needed by the insurance company to process the claim.

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Instructions: Please fill out questionnaire. Parents, please fill out for a young child.

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Some Days	More than half the days	Most every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or let your family down	0	1	2	3
7. Trouble concentrating on things like doing school work or watching television	0	1	2	3
8. Moving or speaking slowly that people have noticed	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
10. Feeling nervous, anxious or on edge	0	1	2	3
11. Not being able to sleep or control worrying	0	1	2	3
12. Worrying too much about different things	0	1	2	3
13. Trouble relaxing	0	1	2	3
14. Being so restless that it is hard to sit still	0	1	2	3
15. Becoming easily annoyed or irritable	0	1	2	3
16. Feeling afraid, as if something awful might happen	0	1	2	3

Column Totals Questions 1 - 9 _____ **Column Totals Questions 10 - 16** _____

A) Has there been a time in the **past month** where you have had serious thoughts about ending your life?
[ ] Yes [ ] No

B) In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes?
[ ] Yes [ ] No

C) Have you **EVER**, in your **WHOLE LIFE**, tried to kill yourself or made a suicide attempt?
[ ] Yes [ ] No

D) If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do, your school work, take care of things at home or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult