LIFE by DESIGN
GREY MATTERS NEUROFEEDBACK
12211 W. ALAMEDA PKWY STE #105
LAKEWOOD, CO 80228
303-249-3622

INTAKE FORM FOR MINOR CHILD (UNDER 15 Years Old)

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better Shari Y. Johansson will be able to assess your minor child's mental health needs. Please provide as much information as possible.

This intake form should be filled out by the Parent(s) or Legal Guardian(s) consenting to mental health services for the minor child listed below. For purposes of mental health treatment in Colorado, a minor child is everyone that is under the age of fifteen (15) years old. The therapist at LIFE by DESIGN / GREY MATTERS NEUROFEEDBACK may interview the child and fill out the applicable sections or may request that the parent(s) or legal guardian(s) fill out the applicable section about their minor child. This is within the sole discretion of Shari Y. Johansson.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Minor Child Client Information:

Client's Name: _____

Gender: ☐Male ☐ Female Client's Birthdate: _____

Client's Address: _____

City: _____ State:_____ Zip Code: _____

Parent(s) or Legal Guardian(s) Information:

Are the child's parents: ☐ Married or Civil Union ☐ Separated ☐ Divorced ☐ Living Together

If the child's parents are no longer together, are either of the child's parents remarried:

☐ YES ☐ NO

Please list any Stepmother and/or Stepfather's Names and telephone numbers:

_____

_____

May Shari Y. Johansson contact any Stepmother and/or Stepfather: ☐ YES ☐ NO

Mother's Name: _____
Mother's Telephone: _____
Mother's Address: _____
Mother's Occupation: _____

Does the child live with his/her Mother: ☐ YES ☐ NO

If yes, does the child live with her: ☐ Full-Time ☐ Part-Time

May Shari Y. Johansson contact mother: ☐ YES ☐ NO

Father's Name: _____
Father's Telephone: _____
Father's Address: _____
Father's Occupation: _____

Does the child live with his/her Father: ☐ YES ☐ NO

If yes, does the child live with him: ☐ Full-Time ☐ Part-Time

May Shari Y. Johansson contact father: ☐ YES ☐ NO

If the minor child's parents are divorced and/or a custody agreement is in place, please state which parent/legal guardian has decision-making authority and custody of the minor child:

_____

If the minor child's parents or legal guardians are not married or are legally separated, please provide the court custody order or custody agreement that states who has decision-making authority and custody of the minor child. **Shari Y. Johansson cannot provide any mental health services until a custody order or custody agreement is provided. It is also beyond the scope of Shari Y. Johansson's practice to provide custody recommendations.**

Contact Information for Consenting Parent/Legal Guardian:

Address: _____

May Shari Y. Johansson contact you at this address: ☐ YES ☐ NO

Home Phone: _____ Cell Phone: _____ Work Phone: _____

May Shari Y. Johansson contact you at all the above telephone numbers provided:
☐ YES ☐ NO

_____

May Shari Y. Johansson leave a voice message at all the above telephone numbers provided:
☐ YES ☐ NO

Email Address: _____ Do you share this email address with anyone else?
☐ YES ☐ NO
If so, please list who else shares the email address: _____

May Shari Y. Johansson contact you at the above email address: ☐ YES ☐ NO

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and cell phone. By allowing Shari Y. Johansson to contact you by email you are consenting to receive electronic communications and understand the risks involved. Shari Y. Johansson cannot guarantee that confidential information shared using electronic communications will remain confidential.**

What is your preferred method of communication:

□Telephone (H) □ Cell Phone, including texts □ Telephone (W) □ Email

Family Information:

Do you have any other children: ☐ YES ☐ NO
How many? _____ Ages:_____

Do your other children live with you: ☐ YES ☐ NO
If no, who do your other children live with:

Are there any other persons that live in your home with you: ☐ YES ☐ NO
If yes, please list their names and ages, and relation to you and/or the child:

Emergency Contact Information:
In case of an emergency, Shari Y. Johansson may be required to contact someone on your behalf. Please list your emergency contact below, which Shari Y. Johansson may contact on your behalf. Shari Y. Johansson will share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: _____

Telephone Number: _____

Relationship to Client: _____

Primary Care Physician Information:
In order to provide your minor child with continuous and congruent care, Shari Y. Johansson may need to contact your child's primary care physician. Any contact that Shari Y. Johansson may have with your child's Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please Provide the Date of Your Child's Last Physical: _____

May Shari Y. Johansson contact your child's physician: ☐ YES ☐ NO

Please list any medication your minor child is currently taking (if your minor child is not currently taking any medication(s), please state so):

_____

_____

_____

Please list any current physical illnesses, issues, and/or ailments your minor child has (if your minor child does not currently have any physical illnesses, issues, and/or ailments, please state so):

_____

_____

_____

Previous/Current Mental Health Provider(s):

In order to provide your minor child with continuous and congruent care, Shari Y. Johansson may need to contact your minor child's previous or current Mental Health Provider. Any contact that Shari Y. Johansson may have with your minor child's previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Please Provide the Date of Your Minor Child's Last Session: _____

May Shari Y. Johansson contact your minor child's previous or current Mental Health Provider:
☐ YES ☐ NO
Is your minor child currently in counseling with the above listed mental health provider:
☐ YES ☐ NO

Have you ever sought counseling for your minor child before: ☐ YES ☐ NO
If yes, please list your reason(s) for seeking mental health services for your minor child (if your minor child is currently seeing another mental health provider, please list the reason(s) here as well):

_____

_____

_____

Minor Child Client's Mental Health:
Please tell us why you are seeking counseling for your minor child and describe any issues/ problems that led you to seek counseling.

_____

_____

_____

_____

_____

How have you or your minor child dealt with these issues/problems in the past:

_____

_____

_____

Please list any past or current psychological illnesses or other mental health issues your minor child has or other issues that you have sensed may/have affect your minor child:

_____

_____

_____

Has your minor child ever been, or is currently, suicidal:

_____

Has your minor child ever attempted to commit suicide:

_____

Has anyone in your family ever attempted or committed suicide:

_____

Have you or your minor child used, or currently use alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones and how often):

_____

_____

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate): ☐ YES ☐ NO

_____

_____

Has your minor child ever tried to hurt himself/herself before? If so, please describe the circumstances and what happened:

_____

_____

Has your minor child ever gotten in trouble at school? If so, please describe the circumstances and what happened afterwards:

_____

_____

Are you currently involved in any civil or criminal legal proceedings: ☐ YES ☐ NO
If yes, please state the reason(s):

_____

_____

Are there any weapons available or unlocked in your home:
☐ YES ☐ NO ☐ Prefer not to Answer
If yes, please list the weapon, where it is located, and who it belongs to:

_____

_____

Does your minor child have a preoccupation with weapons, violence, killing, or fire:
☐ YES ☐ NO ☐ Prefer not to Answer
If yes, please describe:

_____

_____

<u>Minor Child Client's Hobbies and Interests:</u>

Does your child play any sports or musical instruments: ☐ YES ☐ NO
If yes, please list what sports and/or musical instruments he/she plays:

_____

_____

Please list any other hobbies or interests that your minor child has:

_____

How does your minor child normally spend his/her day? What does a typical day look like for him/her?

What school does your child attend and what grade is your child in:

What is your child's favorite subject taught in school:

Please describe your child's strengths, weaknesses, general behavior, and attitude:

Is there anything else you would like Shari Johansson to know:

What would you like to accomplish through therapy and/or any goals you would like your minor child to achieve?:

Are there any restraining orders that Shari Y. Johansson should be aware of: ☐ YES ☐ NO
If yes, please provide a copy of the restraining order and describe the circumstances under which it was ordered):

_____

_____

Who will be dropping off and picking up the minor child at LIFE by DESIGN / GREY MATTERS NEUROFEEDBACK:

_____

_____

*Does Shari Y. Johansson have permission to discuss administrative details, such as appointments and scheduling with this person: ☐ YES ☐ NO

A separate Authorization for Release of Information will be required to discuss any details with the above named individual.

Is there anyone that should **NOT** pick up the minor child at LIFE by DESIGN / GREY MATTERS NEUROFEEDBACK:

_____

_____

Financial Information (Please have the Parent or Legal Guardian Fill out this Portion):

1. Do you intend on using insurance benefits to pay for counseling services: ☐ YES ☐ NO

If yes, please list your insurance company: _____
**a copy of your insurance card is needed for your file

Will you need receipts for your insurance company: ☐ YES ☐ NO

2. Do you intend on a third-party (besides an insurance company) paying for counseling services:

☐ YES ☐ NO

If yes, please provide the following information:

Name: _____

Telephone Number: _____ Fax: _____

Address: _____

Relationship to Client: _____

3. Do you intend on paying for counseling services for your minor child on your own:

☐ YES ☐ NO

Parent or Legal Guardian Affirmation:

By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

_____ _____

Parent/Legal Guardian Signature Date

_____

Relationship to Client

_____

Client Name

Checklist Of Concerns:

Client Name:_____

Please mark all of the areas of concern below that apply to your minor child or that you have for your minor child. You may add a note or details in the space next to the concerns checked.

CONCERN	NOTES	NOW	IN THE PAST
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Childhood issues			
Codependence			
Confusion			
Compulsions			
Decision-making, indecision, mixed feelings, putting off decisions			
Delusions (false ideas)			
Dependence			
Depression, low mood, sadness, crying			
Divorce, separation			
Drug use—prescription medications, over-the-counter medications, street drugs			
Eating problems—overeating, undereating, appetite, vomiting, (see also "Weight and diet issues")			
Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Friendships			

Grieving, mourning, deaths, losses, divorce			
Guilt/Shame			
Headaches, other kinds of pains			
Health, illness, medical concerns, physical problems			
Inferiority feelings			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			
Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nervousness, tension			
Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Panic or anxiety attacks			
Perfectionism			
Pessimism			
Procrastination, laziness			
Relationship problems (with friends, with relatives, or at work)			
School problems			
Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			

Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")			
Shyness, oversensitivity to criticism			
Sleep problems—too much, too little, insomnia, nightmares			
Smoking and tobacco use			
Spiritual, religious, moral, ethical issues			
Stress, relaxation, stress management, stress disorders, tension			
Suspiciousness, distrust			
Suicidal thoughts (Your child or a relative)			
Temper problems, self-control, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			
Weight and diet issues			
Withdrawal, isolating			

❑ Other concerns or issues:

_____

_____

_____

_____

_____

Parent or Legal Guardian Affirmation:
By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

_____ _____
Parent/Legal Guardian Signature Date

_____
Relationship to Client

_____
Client Name