Offbeat Therapy

Admission Form - Child

Legal Name: _____ Preferred Name: _____

DOB/Age: _____ Phone #: _____

Email: _____

Gender: ☐ Female ☐ Male ☐ Transgender F-M ☐ Transgender M-F ☐ Intersex ☐ Other: _____

Parent/Guardian: _____

Address: _____

_____

Emergency Contact: _____ _____
Name Phone

Primary Language: _____ Other Languages spoken in home: _____

Living Situation: ☐ Immed. Family ☐ Extend. Family ☐ Foster Family ☐ Group Home

Siblings: ☐ No ☐ Yes, Names & Ages: _____

Highest Education: _____ Currently in School? ☐ Yes ☐ No, Why: _____

School: _____

How did you find us: _____

Jessica@offbeattherapy.com

Offbeat Therapy

_____
Name

_____
Date

Personal Strengths

What activities do you enjoy & feel you are successful at when you try? _____

_____

Who are some of the influential & supportive people, activities, beliefs in your life? _____

_____

Current Reason for Seeking Counseling

Briefly describe the problem for which you are seeking counseling: _____

_____

What would you like to see happen as a result of counseling? _____

_____

Individual Concerns

SYMPTOM	***NONE***	***MILD***	***MOD***	***SEV***	***SYMPTOM***	***NONE***	***MILD***	***MOD***	***SEV***
Sadness					Appetite Change				
Crying					Social Isolation				
Sleep Disturbances					Paranoid Thoughts				
Problems @ Home					Poor Concentration				
Hyperactivity					Indecisiveness				
Binging/Purging					Low Energy				
Loneliness					Excessive Worry				
Unresolved Guilt					Low Self Worth				
Irritability					Anger Issues				
Phobias					Spiritual Concerns				
Social Anxiety					Hallucinations				
Self-Mutilation					Racing Thoughts				
Cutting					Restlessness				
Impulsivity					Drug/Alcohol Use				
Nightmares					Trauma Flashbacks				
Hopelessness					Obsessive Thoughts				
Elevated Mood					Panic Attacks				
Mood Swings					Anxiety				
Disorganized					Suicidal Thoughts				
Anorexia					Past Suicide Attempts				
Grief									

Offbeat Therapy

_____
Name

_____
Date

PARENT SECTION

Child's Development

1. Are there any current health problems you child is dealing with? _____

   _____

2. Did your child experience any developmental delays (walking, talking)? _____

   _____

3. Did your child have any unusual behaviors or problems prior to age 3? _____

   _____

4. Has your child experienced emotional, physical, or sexual abuse? ☐ Yes ☐ No ☐ Unsure

Counseling History

Has your child previously seen a counselor? ☐ Yes ☐ No

If yes, where: _____

For what reason? _____

Did your child have a previous mental health diagnosis? _____

Has your child taken medication for a mental health concern? ☐ Yes ☐ No

Previous Medication: _____

_____

Family Concerns

Please check any family concerns that you are currently experiencing

	Fighting		Disagreeing about Relatives
	Feeling Distant		Disagreeing about Friends
	Loss of Fun		Job Change
	Lack of Honesty		Alcohol/Drug Use
	Physical Fights		Infidelity (parents)
	Education Problems		Birth of Sibling
	Financial Problems		Feeling Unsafe
	Death of Family Member		Abuse/Neglect

Offbeat Therapy

_____
Name

_____
Date

Parent's Status

☐ Single ☐ Married ☐ Divorced ☐ Cohabitating ☐ Separated ☐ Widowed

Mother's Name: _____ DOB: _____ Age: _____

Total Years of Education: _____ Occupation: _____

Military Experience? Y/N _____ Combat Experience? Y/N _____

Father's Name: _____ DOB: _____ Age: _____

Total Years of Education: _____ Occupation: _____

Military Experience? Y/N _____ Combat Experience? Y/N _____

Is there anything else you would like to share: _____

_____

_____

_____