Danisha Reed, LPC, ACS

Serving Atlantic County

609-447-2419

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Intake (Minor)

Full Name:_____ Name you prefer:_____

Address: City: Zip: _____

Sex: Male Female Birth Date:_____Age:_____ Grade: _____

Home#_____Cell#_____Email_____

Name of Parent/Guardian:_____

Who are you presently living with? _____

School: _____ Job (if none, leave blank): _____

Insurance Information:

Company Name: _____

Phone: _____ ID#: _____ Group #_____

Auth #: _____ Approved dates of Service: _____

Approved # of Sessions:_____

Hobbies: _____

Please describe why you are coming to counseling (i.e. what are the problem(s) that you want help with)?:_____
_____
_____
_____
_____
_____
_____

PROBLEMS CHECKLIST

Please rate each issue: 1 = Major Problem 2 = Sometimes a Problem 3 = Never a Problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Dealing with bullying

_____ Worrying about whether I'm normal

_____ Excessive worry or anxiety

_____ Dealing with my alcohol or drug abuse

_____ Never eating/eating too much and

vomiting to control weight

_____ Trying to decide on a career

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

_____ Dealing with sexual feelings and/or problems

_____ Getting along with my parents or other

family members

_____ Feelings of sadness

Are there any other problems or concerns you would like to

address?_____

_____

_____

Youth signature_____ Date_____

Parent Signature_____ Date_____