HORIZONS FAMILY COUNSELING

1112 South Livermore Avenue
Livermore, CA 94550
(925) 371-4747

COUNSELING INTAKE INFORMATION

(to be completed by the client or parent/guardian)

PLEASE COMPLETE BOTH SIDES OF THIS FORM. THANK YOU.

Child/Client Name	Date of Birth	Occupation or School Name	Grade Level, or Highest Level of Education	Ethnicity	Currently on Probation?	On Probation in Past?
					☐ Yes ☐ No	☐ Yes ☐ Never

Relationship to Adult with Legal Custody: ☐ Biological child ☐ Adopted child ☐ Foster child

Please list all other persons living in the home:

Name *(first, last)*	Relationship to Client *(i.e., mother, sister)*	Date of Birth	Occupation or School Name	Level or Amount of Education	Ethnicity	Probation Now?	Probation Past?	Child is: B=Biological A=Adopted F=Foster S=Step *(circle one)*
						Y N	Y N	B A F S
						Y N	Y N	B A F S
						Y N	Y N	B A F S
						Y N	Y N	B A F S
						Y N	Y N	B A F S
						Y N	Y N	B A F S

Other significant family members **not** living in the home *(i.e., biological parent, adult sibling)*:

Name	Relationship	Age	DOB	Where They are Living

Has your family ever been a victim of crime? ☐ Yes ☐ No

If YES, do you have a VOC case number? ☐ Yes ☐ No

VOC Case # _______________

Language(s) spoken in home:__________________________ Gross Income:$_____________ *(before deductions)*

Other income (including child support, SSI, Medi-Cal):______________ Check one: ☐ weekly ☐ monthly ☐ yearly

Number of dependents:__________ *(number of people this income is supporting)*

Medical Insurance: ☐ Private ☐ Medi-Cal ☐ VOC ☐ None Are mental health benefits covered by this insurance? ☐ Yes ☐ No

If “Private”, name of Insurance:____

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Have you or family members been in counseling in the past? ☐ Yes ☐ No ☐ Currently

If yes, list the counselor/agency, which family members participated, and length of time in counseling:
____

*Please answer the following section **regarding the person being referred for counseling**. You will have an opportunity to explain more about other family members during the session, or you can enter information about other family members in the section below provided for "additional information".*

List any current or past medical conditions:____

Date of last physical:____________ Name of primary care physician or pediatrician: ____________________________

List any prescription medications taken: ____

List any over the counter medications: ____

Please check areas of concern that you have concerning your child/adolescent/self:

☐ anger management	☐ depression	☐ learning issues	☐ shyness	☐ sleep patterns	☐ eating/diet/weight	☐ abuse
☐ anxiety/fears	☐ grief/loss	☐ lying	☐ social skills	☐ drugs or alcohol	☐ divorce/separation	
☐ attention issues	☐ impulse control	☐ self-esteem	☐ trauma	☐ peer problems	☐ domestic violence	

☐ Other: ____

Is there additional information about the client or other family members that might be helpful for the counselor to be aware of (*such as medical conditions, pending divorce, etc*)? ____
____

Please check any of the following that your family may also need information about:

☐ Housing	☐ Employment	☐ Migrant Education	☐ Parenting classes	☐ Medi-Cal	☐ Anger management classes
☐ Transportation	☐ Tutoring	☐ Education	☐ Community Resources	☐ Public assistance *(food stamps or other types of aid)*	

☐ Other: ____

Referred by: *(please check one)*

☐ Livermore PD	☐ Child Protective Services	☐ Parent	☐ AXIS Community Health	☐ Youth Court	
☐ Pleasanton PD	☐ School Attendance Resource Board	☐ Family/Friend	☐ Drug/Alcohol Treatment Center	☐ Kid Connection	
☐ Dublin PD	☐ Probation	☐ Horizons Client	☐ ACCESS/Medi-Cal	☐ Tri-Valley Community Foundation	
☐ Alameda County Sheriff's Office	☐ School	☐ Self	☐ Hospital/Doctor	☐ Website	☐ Other

Please list email address to receive agency and workshop information by email: ______________________________