The Hope Center
For Healing and Health

9365 US Hwy 19 North, Suite A-1, Pinellas Park, FL 33782 · 727-575-7060 · pinellascountycounselor.com

Child & Adolescent Intake Questionnaire

Parent / Guardian Form · For children and teens ages 0–17

Thank you for trusting us with your child's care. Your answers help us understand your child as a whole person: their development, health, family, school, friendships, strengths and worries. Please complete this form before your child's first appointment and bring it with you, or return it as instructed when you booked.

It usually takes 30 to 40 minutes. Answer what you can. If a question doesn't apply or you would rather talk about it in person, write "prefer to discuss" and we will go over it together. There are no right or wrong answers.

Everything you share is confidential and is protected by law. The limits of confidentiality are explained on the consent page at the end of this form.

If your child is in danger right now, call 911 or go to the nearest emergency room. For a mental health crisis, call or text 988 (Suicide & Crisis Lifeline), available 24/7. The Hope Center is not a crisis facility and this form is not monitored for emergencies.

Book an appointment
Tue–Fri, 10 a.m.–7 p.m.

All intake forms
New Patient Intake page

Our website
pinellascountycounselor.com

1. Child and Family Information

Child's full legal name: _____ Today's date: _____

Name your child likes to be called: _____ Date of birth: _____ Age: _____

School: _____ Grade: _____

Language(s) spoken at home: _____

Interpreter needed? ☐ Yes ☐ No

Home address: _____ City: _____ ZIP: _____

Person completing this form

Name: _____ Relationship to child: _____

Cell phone: _____ Other phone: _____ Email: _____

May we leave a voicemail at these numbers? ☐ Yes ☐ No

May we text or email you about scheduling? ☐ Yes ☐ No

Legal custody and consent

Florida law requires written consent from a parent or legal guardian before we can provide counseling to a minor. Please tell us who has legal authority to make health care decisions for your child.

☐ Both parents (shared parental responsibility)
☐ Mother only
☐ Father only
☐ Legal guardian
☐ Grandparent or relative caregiver
☐ Foster care / DCF placement
☐ Other: _____

Is there a parenting plan, custody order or other court order that affects your child's care? ☐ Yes ☐ No

If yes, please bring a copy to the first appointment. We are not able to begin services until we have it.

Emergency contact (name and relationship): _____ Phone: _____

Second emergency contact: _____ Phone: _____

2. What Brings You In

1. In your own words, what are your main concerns about your child right now?

_____

_____

_____

_____

2. When did you first notice these concerns? Did anything happen around that time (a move, loss, change at school, family change)?

_____

_____

3. Who suggested counseling?

☐ My own decision
☐ Pediatrician / doctor
☐ School / teacher / counselor
☐ Court or DCF
☐ My child asked for help
☐ Other: _____

4. How much are these concerns affecting your child in each area? Circle a number.

Area	Not at all					Severely
At home / with family	0	1	2	3	4	5
At school / learning	0	1	2	3	4	5
With friends	0	1	2	3	4	5
Your child's happiness and well-being	0	1	2	3	4	5

5. What have you already tried, and what has helped even a little?

_____

_____

6. If counseling is successful, what would be different for your child and your family? What goals would you like to work toward?

_____

_____

_____

7. Does your child know they are coming to counseling? How do they feel about it?

_____

3. Safety

We ask every family these questions. Answering "yes" does not mean something is wrong with you or your child; it helps us keep your child safe and plan the right care.

	Never	In the past	Recently (past month)
1. Has your child talked about wanting to die, not wanting to be alive, or killing themselves?	☐	☐	☐
2. Has your child ever tried to end their life?	☐	☐	☐
3. Has your child ever hurt themselves on purpose (for example cutting, burning, hitting themselves)?	☐	☐	☐
4. Has your child threatened or tried to seriously hurt someone else?	☐	☐	☐
5. Has your child run away from home or talked about running away?	☐	☐	☐
6. Are you worried that anyone is hurting your child, or that your child is not safe somewhere?	☐	☐	☐

7. Are there firearms in your home or in homes where your child spends time? ☐ Yes ☐ No ☐ Not sure
   If yes, are all firearms stored locked and unloaded, with ammunition locked separately? ☐ Yes ☐ No ☐ Not sure

8. Are medicines (prescription and over-the-counter) kept where your child can't get them? ☐ Yes ☐ No ☐ Not sure

If you answered "Recently" to any question above, please call us at 727-575-7060 before the appointment. If your child is in danger now, call 911 or 988.

4. Emotional and Behavioral Checklist

Pediatric Symptom Checklist (PSC-17), parent version. For children ages 4 to 16. Emotional and physical health go together in children. Please mark the answer that best describes your child over the past few weeks.

	Never (0)	Sometimes (1)	Often (2)	Office
1. Fidgety, unable to sit still	☐	☐	☐	A

	Never (0)	Sometimes (1)	Often (2)	Office
2. Feels sad, unhappy	☐	☐	☐	I
3. Daydreams too much	☐	☐	☐	A
4. Refuses to share	☐	☐	☐	E
5. Does not understand other people's feelings	☐	☐	☐	E
6. Feels hopeless	☐	☐	☐	I
7. Has trouble concentrating	☐	☐	☐	A
8. Fights with other children	☐	☐	☐	E
9. Is down on him- or herself	☐	☐	☐	I
10. Blames others for his or her troubles	☐	☐	☐	E
11. Seems to be having less fun	☐	☐	☐	I
12. Does not listen to rules	☐	☐	☐	E
13. Acts as if driven by a motor	☐	☐	☐	A
14. Teases others	☐	☐	☐	E
15. Worries a lot	☐	☐	☐	I
16. Takes things that do not belong to him or her	☐	☐	☐	E
17. Distracted easily	☐	☐	☐	A
Office use only: Attention (A) ____ / 10 (positive ≥ 7) Internalizing (I) ____ / 10 (positive ≥ 5) Externalizing (E) ____ / 14 (positive ≥ 7) Total ____ / 34 (positive ≥ 15)				

PSC-17 © Jellinek & Murphy, Massachusetts General Hospital. Free for clinical use; used without alteration. A screening tool, not a diagnosis.

Other things you may have noticed

Please check any that apply to your child now (N) or in the past (P).

	N	P		N	P
Worries about being away from parents	☐	☐	Fears (dark, animals, storms, needles)	☐	☐
Panic attacks / racing heart / can't breathe	☐	☐	Stomachaches or headaches with no medical cause	☐	☐
Repeated thoughts or rituals (checking, washing, counting)	☐	☐	Nightmares or trouble sleeping	☐	☐
Avoids reminders of a scary or upsetting event	☐	☐	Easily startled / always on guard	☐	☐
Irritable or angry most days	☐	☐	Big mood swings	☐	☐
Tantrums or meltdowns beyond their age	☐	☐	Argues, defies rules, loses temper often	☐	☐
Cries easily / very sensitive	☐	☐	Withdraws from family or friends	☐	☐
Lost interest in things they used to enjoy	☐	☐	Low energy / tired all the time	☐	☐
Trouble with eating (too much, too little, picky)	☐	☐	Concern about weight or body shape	☐	☐

	N	P		N	P
Tics (repeated movements or sounds)	☐	☐	Bothered by noises, textures, tags, smells	☐	☐
Trouble with back-and-forth conversation	☐	☐	Prefers to play alone / few shared interests	☐	☐
Lies often	☐	☐	Takes things that are not theirs	☐	☐
Destroys property	☐	☐	Fire setting	☐	☐
Hurts animals	☐	☐	Sexual behavior or knowledge unusual for their age	☐	☐
Uses alcohol, vapes, marijuana or other drugs	☐	☐	Excessive gaming or phone use	☐	☐
Hears or sees things others do not	☐	☐	Hard time with change or transitions	☐	☐

5. Pregnancy, Birth and Development

If your child is adopted or you don't know this history, check here and skip to the timeline: ☐ *Unknown / adopted*

1. Any problems during the pregnancy (illness, bleeding, high blood pressure, gestational diabetes, severe stress)?
   ☐ Yes ☐ No ☐ Not sure

_____

2. During pregnancy, was there any exposure to alcohol, tobacco/vaping, marijuana, other drugs or prescription medicines? ☐ Yes ☐ No ☐ Not sure

_____

Born at how many weeks: _____ Birth weight: _____

NICU stay? ☐ Yes ☐ No If yes, how long: _____

3. Any problems during or right after birth (emergency C-section, breathing problems, jaundice needing treatment, feeding problems)? ☐ Yes ☐ No ☐ Not sure

_____

Early development

Compared with other children the same age, when did your child reach these milestones?

Milestone	Age (approx.)	On time	Late	Not sure
Sat up without support		☐	☐	☐
Walked on their own		☐	☐	☐
Said first words		☐	☐	☐
Put two words together ("more milk")		☐	☐	☐
Toilet trained in the daytime		☐	☐	☐
Dry at night		☐	☐	☐

4. Has a doctor, teacher or therapist ever been concerned about your child's development (speech, movement, learning, social skills)? ☐ Yes ☐ No ☐ Not sure

5. Has your child received Early Steps, speech, occupational or physical therapy, or other early intervention? ☐ Yes ☐ No

If yes, what and when: _____

6. Does your child currently have trouble with any of these?

- ☐ Speech is hard to understand
- ☐ Dressing, eating or self-care for their age
- ☐ Holding a pencil, buttons, cutting
- ☐ Eye contact or responding to their name
- ☐ Following directions for their age
- ☐ Running, jumping, riding a bike, balance
- ☐ Pretend or imaginative play
- ☐ Making friends their own age

Life events timeline

List important events in your child's life and how your child reacted. Examples: moves, new siblings, divorce or separation, deaths, hospital stays, hurricanes, school changes, a parent deployed or away.

Child's age	What happened	How your child reacted
Birth–2		
3–5		
6–9		
10–12		
13–15		
16–17		

6. Physical Health

Pediatrician / primary doctor: _____ Phone: _____

Date of last check-up: _____

Hearing or vision concerns? ☐ Yes ☐ No Wears glasses or hearing aids? ☐ Yes ☐ No

1. Does your child have any medical conditions? (for example asthma, seizures, diabetes, thyroid, heart, genetic condition) ☐ Yes ☐ No

_____

Allergies (medicine, food, environmental): _____

2. Current medications, including vitamins and supplements:

Medication	Dose and how often	What it's for	Prescribed by

3. Any surgeries, hospital stays or serious injuries? ☐ Yes ☐ No

_____

4. Has your child ever had a head injury or concussion? ☐ Yes ☐ No

If yes: ☐ Lost consciousness ☐ Changes afterward in behavior, memory or school

When and what happened: _____

Sleep, eating and daily habits

Usual bedtime: _____ Usual wake time: _____ Naps: _____

5. Sleep concerns:

☐ Trouble falling asleep ☐ Wakes during the night ☐ Nightmares or night terrors ☐ Snores loudly / stops breathing

☐ Sleeps in parent's bed ☐ Tired during the day ☐ Wets the bed ☐ No sleep concerns

6. How is your child's appetite? Any big change in weight in the past year?

_____

7. Accidents with urine or bowel movements during the day (after toilet training)? ☐ Yes ☐ No

Screen time on a typical school day (hours): _____

Phone, tablet or game system in the bedroom at night? ☐ Yes ☐ No

Physical activity / sports (hours per week): _____

7. Past Counseling and Mental Health Care

1. Has your child seen a counselor, therapist, psychologist or psychiatrist before? ☐ Yes ☐ No

Provider / program	When	Reason	Was it helpful?

2. Has your child ever been given a mental health, developmental or learning diagnosis? ☐ Yes ☐ No

Diagnosis, by whom, and when: _____

3. Has your child ever had psychological, educational or developmental testing? ☐ Yes ☐ No

If yes, please bring a copy of the report.

4. Has your child ever taken medicine for mental health, attention or behavior? ☐ Yes ☐ No

Which medicines and did they help: _____

5. Has your child ever been hospitalized, Baker Acted, or gone to a crisis center for mental health? ☐ Yes ☐ No

Where and when: _____

8. Family and Home

1. Who lives in your child's home(s)?

Name	Age	Relationship to child	Lives with child?	How they get along

2. If parents live apart, what is the schedule for time with each parent? How does your child handle going between homes?

_____

_____

3. Parents / caregivers:

	Parent / caregiver 1	Parent / caregiver 2	Step-parent / other
Name			
Age			
Occupation			
Lives with child?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Phone			

4. Have any of these happened in your family in the past two years?

☐ Separation or divorce
☐ Remarriage or new partner
☐ New baby or sibling
☐ Move to a new home or school
☐ Death of a family member or pet
☐ Serious illness in the family
☐ Job loss or money stress
☐ Parent deployed, working away, or incarcerated
☐ Hurricane, fire or other disaster
☐ Housing or food worries
☐ Other: _____
☐ None of these

5. What daily routines does your child have (mornings, homework, meals, bedtime)? How well do they work?

6. How do you handle misbehavior at home? What works best? Who usually handles discipline?

7. How does your family handle disagreements and stress?

8. What does your family enjoy doing together? What are your family's strengths?

Family health history

Many conditions run in families. Check any that a blood relative has had, and write who (for example "maternal uncle").

Condition	Who	Condition	Who
☐ Depression		☐ Anxiety or panic	
☐ Bipolar disorder		☐ ADHD	
☐ Autism		☐ Learning disability	
☐ Schizophrenia or psychosis		☐ Alcohol or drug problem	
☐ Suicide attempt or death by suicide		☐ Eating disorder	
☐ OCD or tics		☐ Seizures or other neurological condition	

9. Stressful or Upsetting Experiences

Difficult experiences can affect how children feel, behave, learn and sleep. Knowing about them helps us give the right kind of care. You do not need to give details here; check what applies and we can talk privately.

	Yes	No	Not sure
Death of someone close to your child	☐	☐	☐
Serious accident, injury, illness or medical procedure	☐	☐	☐
Hurricane, fire, flood or other disaster	☐	☐	☐
Saw or heard violence or fighting between adults at home	☐	☐	☐
Saw or experienced violence at school or in the community	☐	☐	☐
Bullied in person or online	☐	☐	☐
Hit, hurt or threatened by an adult	☐	☐	☐

	Yes	No	Not sure
Sexually abused or touched in an unwanted way	☐	☐	☐
Often insulted, put down or made to feel afraid by an adult	☐	☐	☐
Not given enough food, care or supervision	☐	☐	☐
Separated from a parent (custody change, foster care, incarceration, deportation)	☐	☐	☐
Lived with someone with a serious alcohol, drug or mental health problem	☐	☐	☐

Has any of this been reported to the Florida Abuse Hotline, DCF or law enforcement? ☐ Yes ☐ No ☐ Not sure

Please know: as counselors, we are required by Florida law to report any suspicion that a child is being abused, abandoned or neglected (s. 39.201, Florida Statutes). If you have a concern that has not been reported, you can also call the Florida Abuse Hotline yourself at 1-800-96-ABUSE (1-800-962-2873) or report online at reportabuse.dcf.state.fl.us.

10. School and Learning

School type: ☐ Public ☐ Private ☐ Charter ☐ Home school ☐ Virtual ☐ Not in school yet

1. Grades this year compared with last year: ☐ Better ☐ About the same ☐ Worse
2. School supports: ☐ IEP ☐ 504 Plan ☐ Being evaluated ☐ None
3. Has your child ever repeated a grade? ☐ Yes ☐ No
4. Any suspensions, expulsions or frequent calls home about behavior? ☐ Yes ☐ No
5. Does your child miss school often or refuse to go? ☐ Yes ☐ No
6. Does your child have trouble with reading, writing, spelling or math? ☐ Yes ☐ No
7. What do teachers say about your child (behavior, attention, effort, friendships)?

_____

_____

8. What subjects or school activities does your child enjoy most?

_____

11. Friends, Activities and Technology

1. Does your child have friends their own age? Do friendships last? ☐ Yes ☐ No

_____

2. How does your child get along with other children and with adults they don't know?

_____

3. What does your child like to do for fun? Sports, clubs, music, art, faith activities, other interests?

_____

_____

4. Which social media, games or apps does your child use?

_____

5. Any worries about your child's online activity (contact with strangers, sharing pictures, cyberbullying, time spent)?
☐ Yes ☐ No ☐ Not sure

_____

12. Substance Use and Legal Involvement

For children 10 and older. Answer to the best of your knowledge; we will also ask teens privately.

Has your child used:	No	Tried it	Uses sometimes	Uses often	Not sure
Alcohol	☐	☐	☐	☐	☐
Vape, e-cigarettes or tobacco (including nicotine pouches)	☐	☐	☐	☐	☐
Marijuana / THC (including edibles, vapes, delta-8)	☐	☐	☐	☐	☐
Someone else's prescription medicine	☐	☐	☐	☐	☐
Other drugs	☐	☐	☐	☐	☐

1. Is your child currently involved with juvenile court, the Department of Juvenile Justice, or a diversion program?
☐ Yes ☐ No

2. Is there an open DCF case, custody case or other court matter involving your child? ☐ Yes ☐ No

If yes, please explain (case worker or attorney name if applicable): _____

_____

13. Culture, Faith and Values

1. What is your family's cultural or ethnic background, and is there anything about your culture we should understand in caring for your child?

_____

_____

2. Is faith or spirituality important to your family? ☐ Very ☐ Somewhat ☐ Not really

Faith community or tradition (optional): _____

3. Would you like your family's beliefs and values considered in your child's counseling? ☐ Yes ☐ No ☐ Let's discuss

14. Your Child's Strengths

1. What are your child's greatest strengths? What do you love and admire about them?

_____

_____

_____

2. What helps your child calm down or feel better when they are upset?

_____

_____

3. Who are the important supportive people in your child's life (relatives, coaches, teachers, mentors, faith leaders)?

_____

4. Is there anything else you would like us to know to better understand and help your child?

_____

_____

_____

_____

For Counselor Use

Additional standardized measures, selected by age and presenting concern:

- ☐ SCARED – anxiety (parent & child, ages 8–18)
- ☐ PHQ-A – depression (teen self-report, ages 11–17)
- ☐ Columbia Suicide Severity Rating Scale (C-SSRS)
- ☐ Child PTSD Symptom Scale (CPSS-5) – trauma (ages 8–18)
- ☐ Ages & Stages Questionnaires: SE-2 (under 6)
- ☐ Vanderbilt ADHD Rating Scales – parent & teacher (ages 6–12)
- ☐ ASQ – suicide risk screen (youth, ages 10+)
- ☐ CRAFFT 2.1 – substance use (ages 12–21)
- ☐ PSC-17 youth self-report (ages 11+)
- ☐ Other: _____

Reviewed by: _____ Date: _____ PSC-17 total: _____

Consent for Counseling Services for a Minor

Counselor: Pamela Wiggins, LMHC (MH #6978), The Hope Center for Healing and Health.

Voluntary services. I am voluntarily requesting outpatient counseling for my child and, as needed, our family, in person or by secure telehealth. I may stop services at any time. I understand counseling may include assessment, individual, family and parent sessions.

Legal authority to consent. I confirm that I am the child's parent or legal guardian with authority to consent to health care, as required by Florida law (s. 1014.06, F.S.). If a parenting plan or court order affects decision-making, I have provided or will provide a copy. I understand the counselor's role is therapeutic and is not a custody evaluation.

What to expect. My child's counselor will explain the treatment plan, approaches used, expected benefits, possible risks (such as uncomfortable feelings while working through problems) and alternatives, and I am encouraged to ask questions and take part in planning my child's care.

Confidentiality. What my child and family share is confidential and protected by law (s. 491.0147, F.S.). To help my child feel safe talking, the counselor will usually share general progress and safety concerns with me rather than every detail of my child's sessions. We will agree on this together at the start of counseling.

Limits of confidentiality. Information may be shared without my permission when: (1) there is suspected abuse, abandonment or neglect of a child or vulnerable adult, which must be reported to the Florida Abuse Hotline; (2) someone makes a specific threat to seriously harm an identifiable person and appears able to act, in which case law enforcement must be notified; (3) my child is at serious risk of harming themselves; (4) a court orders release of records; or (5) as otherwise required by law.

Fees. The Hope Center is private pay and does not bill insurance. Sessions are $180 for 60 minutes, due at the time of service. I have the right to receive a Good Faith Estimate of expected costs. For more information, visit cms.gov/nosurprises or call 1-800-985-3059.

Emergencies. The Hope Center does not provide emergency or after-hours crisis services. In an emergency I will call 911, call or text 988, or go to the nearest emergency room.

My signature below means I have read this form, had the chance to ask questions, and consent to counseling services for my child.

Parent / guardian signature: _____ Date: _____

Printed name: _____ Relationship: _____

Second parent / guardian signature (if shared): _____ Date: _____

Printed name: _____ Relationship: _____

Child or teen agreement (assent), when appropriate: I know what counseling is, and I agree to come and talk with my counselor.

Child / teen signature: _____ Date: _____

Counselor signature: _____ Date: _____

Client and Family Rights

These rights apply to every child and family member taking part in services.

1. To be treated with dignity, consideration and respect.
2. To receive services without discrimination based on race, color, religion, national origin, sex, age or disability.
3. To receive clear, current information about assessment results, diagnosis, treatment and progress in words you can understand.
4. To know the name and credentials of the counselor providing care.
5. To give informed consent before services begin, including the nature, expected length, risks and benefits of treatment and reasonable alternatives.
6. To be free from physical, sexual, psychological, emotional, spiritual and financial abuse, and from physical punishment.
7. To take part in developing and updating the treatment plan, including plans for ending services and aftercare.
8. To refuse or stop any part of treatment after its possible effects have been explained.
9. To privacy and to confidential handling of all records and communications, as allowed by law.
10. To request a copy of records as allowed by Florida and federal law.
11. To a clear understanding of fees, session length, cancellations, payment, and how to reach the office.
12. To receive a Good Faith Estimate of expected costs for services.
13. To know the rules and expectations that apply during services.
14. To share opinions, concerns or complaints and receive a timely response, without any effect on your child's care.

> **Concerns or complaints.** Please talk with your counselor first; we want to hear from you and make things right. You may also contact the Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling at floridasmentalhealthprofessions.gov.

I have received a copy of these rights, and they have been explained to my satisfaction.

Parent / guardian signature: _____ Date: _____

Counselor signature: _____ Date: _____