THE HOUSE OF HOPE
Phone: 715-483-3000
www.thehouseofhope3.com

Afton Location:
3411 St. Croix Trail South
Afton, MN 55001

St. Croix Falls Location:
2070 Hwy. 8
St. Croix Falls, WI 54024

Child Intake

To best meet your needs, the information below will maximize your time here. Please allow 30-60 minutes to complete this survey prior to your first appointment. Write "N/A" for anything that does not apply.

Child Name: _____ Date: _____

Birth Date: _____ Age: _____ School Name: _____ Grade: _____

Mother's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Secondary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Email Address: _____ OK to Email? Yes _____ No _____

Father's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Secondary Phone #: _____ (cell, home, or work) Messages OK? Yes _____ No _____

Email Address: _____ OK to Email? Yes _____ No _____

Emergency Contact: _____ Phone #: _____

Primary Insurance: **Secondary Insurance:**

Health Plan		Health Plan	
Policy Holder		Policy Holder	
Member ID#		Member ID#	
Group/Policy #		Group/Policy #	

Responsibility Party: _____ Relationship to Client: _____

Please summarize the reasons that led you to seek our services:

_____

_____

_____

_____

_____

_____

_____

Child's Counseling Focus
CIRCLE any problems your child is experiencing or stressors within the child's environment:

Depression	Emotional	Employment	Housing	Disability
Anxiety	Grief/Loss	Anger/Violence	Physical health	Mental health
Emotional	Health	Spiritual health	Sexuality	Relationships
Education	Finances	Legal issues	Military issues	Cultural issues
Social Life	Housing	Addiction—self	Addiction—other	Abuse
Trauma	Disability	Lifestyle	Self-harm	

What previous or current counseling/therapy or treatments has your child experienced?

Name of Practitioner	Year	Approximate # of Sessions

What goals would you like to see your child achieve in therapy?

1. _____

2. _____

3. _____