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ADOLESCENT INTAKE FORM

Adolescent please fill out pages 1-8, parent/guardian please fill out pages 9-18

Name: _____Today's Date:_____

❒ Male ❒ Female ❒ Transgender Age:_____ Phone (Cell): _____

Is it okay to leave you a messages on your cell? ❒ Yes ❒ No Text reminders okay? ❒ Yes ❒

School: _____ Grade: _____

Religious Preference: _____ Race/Ethnic Origin: _____

PERSONAL STRENGTHS

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

_____

_____

Who/what are some positive or helpful *people*, *activities* (e.g. walking), or *beliefs* (e.g. religion) in your life?

_____

_____

_____

CURRENT REASON FOR SEEKING COUNSELING

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

_____

_____

_____

_____

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

_____

_____

_____

_____

COUNSELING AND MENTAL HEALTH

Have you previously seen a counselor? ❒ Yes ❒ No

If yes, what did you find ***most helpful*** *in therapy*? _____

_____

If yes, what did you find **least helpful** in therapy? _____

_____

Are you <u>currently</u> hopeful about your future? □ Yes □ No

Are you *<u>currently</u>* having suicidal thoughts? □ Frequently □ Sometimes □ Rarely □ Never

Have you recently done anything to <u>hurt</u> yourself? □ Yes □ No

Do you have a <u>plan</u> to commit suicide*?* □ Yes □ No

Do you <u>intend</u> to commit suicide*?* □ Yes □ No

If yes, do you have the <u>means</u> to commit suicide? □ Yes □ No

Have you had suicidal thoughts in the *past*? □ Frequently □ Sometimes □ Rarely □ Never

If you checked any box other than "never," when did you have these thoughts?_____

If you checked any box other than "never," did you ever act on them? □ Yes □ No

If you have had thoughts of suicide, what positive people or things in your life give you strength to keep going?

_____

_____

Are you having current homicidal thoughts (i.e., thoughts of hurting someone else)? □ Yes □ No

Have you previously had homicidal thoughts? □ Yes □ No *If yes,* when?_____

PEER RELATIONS

How do you consider yourself socially *(check one)*? Outgoing _____ *Shy*_____ Depends on the situation_____

Are you happy with the friends you have? ❒ Yes ❒ No *If no, please explain briefly:* _____

_____

Have you ever been bullied? ❒ Yes ❒ No *If yes, when*?_____

If yes, what happened?_____

Are your parents happy with your friends? ❒ Yes ❒ No *If no, please explain briefly:* _____

_____

Are you involved in any organized social activities (e.g. sports, scouts, music)? _____

_____

Preference for romantic partner: Females ❒ Males ❒ Both ❒

Are you currently in a romantic relationship? ? ❒ Yes ❒ No *If yes, for how long*? _____

If yes, are you satisfied with your relationship? ❒ Yes ❒ No

Do you have any concerns about your safety with your partner (e.g. domestic violence, threats, etc.)? ❒ Yes ❒ No

Please Share electronic communication (e.g. FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

_____

Do your parents have access to your electronic communication? ❒ Yes ❒ No

Do they have any issues with your use of phone, text, electronic communication? ❒ Yes ❒ No

SCHOOL

Do you like school? ❒ Yes ❒ No Do you attend regularly? ❒ Yes ❒ No

What are your current grades? _____

Do you feel you are doing the best you can at school? ❒ Yes ❒ No *If no, please explain briefly:*_____

_____

What subjects or activities do you **most** enjoy? _____

What subjects or activities do you **least** enjoy? _____

DRUG AND ALCOHOL USE

Do you currently use alcohol? ❒ Yes ❒ No

If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely

If yes, what do you typically drink (e.g. beer, wine, vodka, etc)?_____

If yes, how much do you typically drink (e.g. two shots, one 4 oz glass) each time? _____

Do you currently use Tobacco? ❒ Yes ❒ No

If yes, how much do you smoke/chew? _____

Do you currently use any drugs recreationally (e.g. marijuana, ecstasy, etc.)? ❒ Yes ❒ No

If yes, what drugs do you use? _____

If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely

Have you received any previous treatment for chemical use? _____Yes _____No

If yes, was your treatment: Inpatient _____ Outpatient _____ Program Name:_____

Please answer the following with **Y/N**

1. Have you ever used more than 1 chemical at the same time to get high? _____
2. Do you avoid family activities so you can use? _____
3. Do you have a group of friends who also use? _____
4. Do you use to improve your emotions such as when you feel sad or depressed? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past: _____

_____

FAMILY HISTORY

How would you describe your parents' relationship? _____

_____

Did you experience any abuse as a child inside or outside your home (physical, verbal, emotional, or sexual)? (*Please share as much as you feel comfortable)*

_____

_____

_____

<u>CURRENT</u> FAMILY CONCERNS (*Please check all that apply*)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other:

HEALTH

How would you rate your **current** physical health? (*circle one)*

Poor Unsatisfactory Satisfactory Good Very Good

How many ours per night do you normally sleep? _____

Are you having any problems with your sleep habits? □ Yes □ No *If yes,* check where applicable*:*

□ Sleeping too little □ Sleeping too much □ Can't fall asleep □ Can't stay asleep □ Nightmares

Do you exercise regularly? □ Yes □ No

If yes, how many times per week do you exercise? _____ For how long? _____

What do you do?_____

Are you having any difficulty with appetite or eating habits? □ Yes □ No *If yes,* check where applicable:

□ Eating less □ Eating more □ Binging □ Purging

Any significant weight change in the past two months? □ Yes □ No *If yes,* was it planned? □ Yes □ No

Do you drink caffeinated drinks? □ Yes □ No *If yes,* # of sodas per day_____ # of cups of coffee per day_____

Is there anything else that you would like me to know? *(If so, please use the space provided below before proceeding to the next page)*

INDIVIDUAL CONCERNS (Please check one box for each symptom)

SYMPTOM	NONE	MILD	MOD	SEVERE	Comments
Sadness					
Crying					
Sleep disturbances					
Problems at home					
Hyperactivity					
Binging/purging					
Loneliness					
Unresolved guilt					
Irritability					
Nausea/indigestion					
Social anxiety					
Self mutilation					
Cutting					
Impulsivity					
Nightmares					
Hopelessness					
Elevated mood					
Mood swings					
Disorganized					
Anorexia					
Grief					
Phobias					
Headaches					
Weight changes (unplanned changes)					

SYMPTOM	NONE	MILD	MOD	SEVERE	Comments
Appetite changes					
Social isolation					
Paranoid Thoughts					
Poor Concentration					
Indecisiveness					
Low energy					
Excessive worry					
Low self worth					
Anger issues					
Spiritual Concerns					
Hallucinations					
Racing thoughts					
Restlessness					
Drug use					
Alcohol use					
Easily distracted					
Trauma flashbacks					
Obsessive Thoughts					
Panic attacks					
Feeling anxious					
Feeling panicky					
Suicidal thoughts					
Past suicide Attempts					
Other					

Thank you for taking your time to provide this information!

ADOLESCENT INTAKE - PARENT SECTION

Adolescent's Name: _____ Age: _____

Date of Birth: _____ Physician's Name:_____

Person to contact in case of an emergency:

_____ _____ _____
(Name) (Relationship to client) (Phone)

Current household and family information:

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

Biological Parent's Marital Status:

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed

Other: _____

Length of marriage/relationship: _____ If divorced, how old was your child? _____

If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

Please fill out the sections below for each parent/guardian

Parent/Guardian:_____ Birthdate:_____ Age:_____

❒ Male ❒ Female Ethnicity:_____ Religious Preference:_____

Address: _____

City: _____ Zip Code: _____

Email: _____ May I email you? ❒ Yes ❒ No

Place of Employment: _____ Total years of education:_____

Occupation:_____ Work #: _____

Cell #: _____ Home #: _____

Are there any contact methods through which you DO NOT want me to **call** or **leave a message**? _____

Parent/Guardian:_____ Birthdate:_____ Age:_____

❒ Male ❒ Female Ethnicity:_____ Religious Preference:_____

Address: _____

City: _____ Zip Code: _____

Email: _____ May I email you? ❒ Yes ❒ No

Place of Employment: _____ Total years of education:_____

Occupation:_____ Work #: _____

Cell #: _____ Home #: _____

Are there any contact methods through which you DO NOT want me to **call** or **leave a message**? _____

ADOLESCENT'S STRENGTHS

At what activities do you feel your son or daughter is successful when he or she tries? _____

_____

What strengths or characteristics stand out in your son or daughter? _____

_____

Who/what are some of the positive or helpful *people, activities* (e.g. walking), or *beliefs* (e.g. religion) in your

adolescent's life? _____

_____

CURRENT REASON FOR SEEKING COUNSELING

Please briefly describe the problem for which your adolescent is seeking counseling: _____

_____

_____

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

_____

_____

What is most concerning right now? _____

_____

_____

COUNSELING HISTORY

Has your son or daughter previously seen a counselor? ❒ Yes ❒ No *If yes, where*: _____

Approx. dates & duration of counseling: _____

For what reason did your son or daughter go to counseling? _____

_____

Please list any previous mental health diagnoses: _____

What was **most helpful** about therapy? _____

_____

What was **least helpful** about therapy? _____

_____

Has your son or daughter used psychiatric services? ❒ Yes ❒ No *If yes, Doctor's name*: _____

Has your son or daughter taken medication for a mental health concern? ❒ Yes ❒ No *If yes, please list below:*

Name of medication	Dates taken	Was it helpful? (Y/N)

Has your son or daughter been hospitalized for mental health reasons? ❒ Yes ❒ No *If yes*, when? _____

If yes, please describe: _____

_____

INTERNET/ELECTRONIC COMMUNICATIONS

Please list any electronic communication (e.g. FaceBook, Twitter, SnapChat, Instagram, etc) that your child uses:

_____

Do you have access to your child's electronic communication? ❒ Yes ❒ No

Do you have any concerns with your son or daughter using the internet? ❒ Yes ❒ No

If yes, please explain your concern: _____

_____

PEER RELATIONSHIPS

How would you describe your child in social situations?

___Spontaneous ___Follower ___Leader ___Apathetic about making friends
___Makes friends easily ___Shares easily ___ Long term ___Trouble making friends
___Other (describe):_____

EDUCATION

Type of school: _____Public _____Private _____Home Schooled _____Other: _____

School Counselor Name: _____ Phone #: _____

In special education? ❒ Yes ❒ No

If yes, describe: _____

In gifted program? ❒ Yes ❒ No

If yes, describe: _____

Has your child ever been held back in school? ❒ Yes ❒ No *If yes, what grade(s)?* _____

Which subject(s) does your child enjoy in school: _____

Which subject(s) does your child dislike in school: _____

What grades does your child usually receive in school? _____

Any recent changes in grades? ❒ Yes ❒ No

If yes, describe: _____

Any past psychological or academic testing? ❒ Yes ❒ No

If yes, describe: _____

Has your child ever been bullied? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? ❒ Yes ❒ No

If yes, please explain your concern: _____

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant impact on you or your son or daughter in the past: _____

_____

FAMILY HISTORY

Did **you/your spouse** experience any abuse as a **child** (physical, verbal, emotional, or sexual)? ❒ Yes ❒ No

If yes, please describe as much as you feel comfortable: _____

_____

_____

Did **you/your spouse** experience any abuse as an **adult** (physical, verbal, emotional, or sexual)? ❒ Yes ❒ No

If yes, please describe as much as you feel comfortable: _____

_____

_____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Please circle any that apply and list the family member, e.g., sibling, parent, uncle, etc.):

Difficulty		**Family Member(s)**
Depression	yes/no	_____
Bipolar Disorder	yes/no	_____
Anxiety Disorders	yes/no	_____
Panic Attacks	yes/no	_____
Schizophrenia	yes/no	_____
Alcohol/Substance Abuse	yes/no	_____
Eating Disorders	yes/no	_____
Learning Disabilities	yes/no	_____
Trauma History	yes/no	_____
Suicide Attempts	yes/no	_____
Psychiatric Hospitalizations	yes/no	_____

<u>CURRENT</u> FAMILY CONCERNS (*Please check all that apply*)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

As the father, how would you characterize your relationship with your child? Poor ❒ Fair ❒ Good ❒

As the mother, how would you characterize your relationship with your child? Poor ❒ Fair ❒ Good ❒

Is there anything significant about your relationship that might be affecting your child's behavior? ❒ Yes ❒ No

*If yes, please describe:*_____

_____

Have there been stressful events in the child's life in the last 18 months (i.e. moves, deaths, injuries, etc.)? ❒ Yes ❒ No

If yes, please describe: _____

_____

HEALTH AND DEVELOPMENT

This adolescent is number _____ of _____ total children Parent(s) age(s) at child's birth: _____

Was the pregnancy planned? ❒ Yes ❒ No Length of pregnancy: _____

While pregnant, did the mother smoke? ❒ Yes ❒ No *If yes, what amount?* _____

While pregnant did the mother use drugs/alcohol? ❒ Yes ❒ No *If yes, type/amount?*_____

While pregnant, did the mother have medical/emotional difficulties? (i.e. surgery, anxiety etc.) ❒ Yes ❒ No

If yes, describe:_____

Were there any complications with the pregnancy or delivery of your child? ❒ Yes ❒ No

If yes, describe: _____

Did your child have health problems at birth? ❒ Yes ❒ No

If yes, describe: _____

Has the mother had any occurrences of miscarriages, stillborn, or loss of a child? ❒ Yes ❒ No

If yes, please describe: _____

Did your child experience any developmental delays (e.g. toilet training, talking)? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

Did your child have any unusual behaviors or problems prior to age 3? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

Has your child experienced emotional, physical, or sexual abuse? ❒ Yes ❒ No ❒ Not sure

If yes, describe: _____

Date of adolescent's last physical examination: _____

Please list any chronic health problems or concerns (e.g. asthma, migraines, hyperthyroidism, chronic pain, seizures, etc.): _____

_____

Has your child ever been hospitalized? □ Yes □ No

If yes, when and what happened?_____

Any Allergies? □ Yes □ No *If yes,* please list:_____

Current Medications:_____

Has your adolescent ever had a head injury? □ Yes □ No

If yes, when and what happened?_____

CURRENT CONCERNS ABOUT YOUR ADOLESCENT (*Please check one box for each symptom*)

SYMPTOM	*NONE*	*MILD*	*MOD*	*SEVERE*	SYMPTOM	*NONE*	*MILD*	*MOD*	*SEVERE*
Sadness					**Appetite changes**				
Crying					**Social isolation**				
Sleep disturbances					**Paranoid Thoughts**				
Problems at home					**Poor Concentration**				
Hyperactivity					**Indecisiveness**				
Binging/purging					**Low energy**				
Loneliness					**Excessive worry**				
Unresolved guilt					**Low self worth**				
Irritability					**Anger issues**				
Nausea/indigestion					**Spiritual Concerns**				
Social anxiety					**Hallucinations**				
Self mutilation					**Racing thoughts**				
Cutting					**Restlessness**				
Impulsivity					**Drug use**				
Nightmares					**Alcohol use**				
Hopelessness					**Easily distracted**				
Elevated mood					**Trauma flashbacks**				
Mood swings					**Obsessive Thoughts**				
Disorganized					**Panic attacks**				
Anorexia					**Feeling anxious**				
Grief					**Feeling panicky**				
Phobias					**Suicidal thoughts**				
Headaches					**Other:**				
Weight changes -unplanned									