restorative conversations

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Welcome to Restorative Conversations. Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (ages 12-17)

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-8

CLIENT INFORMATION

Name:_____

Date of Birth: _____Age: _____ ❑ Male ❑ Female ❑ Transgender

Phone (Cell): _____Messages okay?_____ Text reminder okay?_____

School: _____ Grade: _____

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

_____

Do your parents have access to your electronic communication? (Y/N) _____Do they have any issues with your use of phone, text, electronic communication? (Y/N)_____

PERSONAL STRENGTHS

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

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for?

_____

_____

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

_____

COUNSELING/MEDICAL HISTORY

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?

_____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? ❑ Yes ❑ No
If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely
If yes, how much do you drink? _____(#) per time.
Do you currently use Tobacco? ❑ Yes ❑ No
If yes, how much do you smoke/chew? _____
Do you currently use any other drugs? ❑ 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 so, where did you go?_____ ____Inpatient _____Outpatient

Adolescents (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

1. Are your parents married or divorced?_____
2. Do you think their relationship is good? (Y/N/Unsure)_____
3. If your parents are divorced, whom do you primarily live with? _____
4. How often do you see each parent? Mom_____% Dad _____%.
5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

	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

Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially: ____outgoing ____shy ____depends on the situation.
2. Are you happy with the amount of friends you have? (Y/N)_____
3. Have you ever been bullied? (Y/N) _____
4. Are your parents happy with your friends? (Y/N)_____
5. Are involved in any organized social activities (e.g. sports, scouts, music)? _____

SCHOOL HISTORY

1. Do you like school? ❑ Yes ❑ No
2. Do you attend regularly? ❑ Yes ❑ No
3. What are your current grades? _____
4. Do you feel you are doing the best you can at School? ❑ Yes ❑ No

INDIVIDUAL CONCERNS

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 grief						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						Past Suicide attempts				
Weight Changes (unplanned)						Other				

*We would like you to know that we have worked with a lot of adolescents and that we respect your privacy and we hope to create an atmosphere where you feel comfortable sharing.

Welcome to Restorative Conversations and the Centre for ADHD. Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name:_____

Date of Birth: _____Age: _____ ❑ Male ❑ Female ❑ Transgender

Race/Ethnic Origin: _____Religious Preference: _____

Street Address:_____ City:_____ Province:_____

Home Phone: _____Work phone: _____Cell Phone:_____

School:_____ Grade:_____

Physcian:_____Phone:_____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

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

(If additional space is needed please list on the back of the page)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_____

_____

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

_____

_____

What is most concerning right now?

_____

_____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? ❑ Yes ❑ No If yes, describe:

_____

2. Did your child have health problems at birth? ❑ Yes ❑ No If yes, describe:

_____

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
❑ Yes ❑ No ❑ Not sure If yes, describe:

_____

_____

4. Did your child have any unusual behaviors or problems prior to age 3? ❑ Yes ❑ No ❑ Not Sure If yes, describe: _____

5. Has your child experienced emotional, physical, or sexual abuse? ❑ Yes ❑ No ❑ Not sure
If yes, describe: _____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ❑ Yes ❑ No If Yes, where:

_____

Approximate Dates of Counseling:

_____

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

_____

_____

Does your son or daughter have a previous mental health diagnosis?

_____

What did you find **most helpful** in therapy?

_____

_____

What did you find **least helpful** in therapy?

_____

_____

Has your son or daughter used psychiatric services? ❑ Yes ❑ No If Yes, who did they see?

_____

If yes, was it helpful? N/A____ ❑ Yes ❑ No

Has your son or daughter taken medication for a mental health concern? ❑ Yes ❑ No

Name of Medication	Dates Taken	Was it helpful (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? ❑ Yes ❑ No
If so, please 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:

_____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? ❑ Yes ❑ No If yes, please explain your concern:

_____

_____

LEGAL ISSUES

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

_____

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3?

_____

_____

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

_____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

_____

_____

PARENT'S MARITAL STATUS (this question refers to the biological parents relationship)

❑ Single ❑ Partnered ❑ Married(legally) ❑ Divorced ❑ Divorce in process ❑ Separated ❑ Widowed ❑ other

Length of marriage/relationship:_____ If divorced, how old was your child at time of divorce? _____
If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father's Name: _____**Birth Date:**_____**Age:** _____

Ethnic Origin:_____

Total years of education completed: _____ Occupation:_____

Place of Employment:

_____

Current Status

❑ Single ❑ Partnered ❑ Married(legally) ❑ Divorced ❑ Divorce in process ❑ Separated ❑ Widowed
Please answer if you are no longer with your child's bio-mother OR check here if you are still with bio-mother _____

Assessment of current relationship if applicable: ❑ poor ❑ fair ❑ Good

Biological Mother's Name: _____ **Birth Date:** _____ **Age:** _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment:

_____

Current Status

❑ Single ❑ Partnered ❑ Married(legally) ❑ Divorced ❑ Divorce in process ❑ Separated ❑ Widowed
Please answer if you are no longer with your child's bio-father OR check here if you are still with bio-father _____

Assessment of current relationship if applicable: ❑ poor ❑ fair ❑ Good

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

	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

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____

_____

What personal qualities would you say your son or daughter has?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

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 grief						Low self worth				
Irritability						Anger Issues				
Nausea/Indigestion						Spiritual Concerns				
Social anxiety						Hallucinations				
Self-mutilation						Racing thoughts				
Cutting						restlessness				
Impulsivity						Drug Use				
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Elevated Mood						Trauma Flashbacks				
Mood Swings						Obsessive thoughts				
Disorganized						Panic Attacks				
Anorexia						Feeling Anxious				
Grief						Feeling Panicky				
Phobias						Suicidal Thoughts				
Headaches						Past Suicide attempts				
Weight Changes (unplanned)						Other				

Is there anything else you would like to share: