Adolescent Intake Form

CLIENT INFORMATION

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female

Physical Address:

Mailing Address:

Phone (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Voicemail Messages okay?

Phone (Home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Voicemail Messages okay?

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:

Race/Ethnic Origin:

Religious Preference:

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 counseling?

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

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Y/N

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? Y/N

If so, where did you go?

\_\_\_\_Inpatient \_\_\_\_Outpatient

ADOLESCENTS (please answer the following with Y/N)

Have you ever used more than 1 chemical at the same time to get high?

Do you avoid family activities so you can use?

Do you have a group of friends who also use?

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

Are your parents married or divorced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you think their relationship is good? (Y/N/Unsure)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If your parents are divorced, whom do you primarily live with? \_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you see each parent? Mom\_\_\_\_\_\_\_\_\_% Dad \_\_\_\_\_\_\_\_\_\_\_%.

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 or Drug use
* Lack of honesty Trauma
* Medical Concerns Infidelity (couple)
* Education problems Divorce/separation
* Financial problems Issues regarding remarriage
* Death of a family member Birth of a child
* Inadequate health insurance Job change or job dissatisfaction
* Inadequate housing/feeling unsafe Other
* Other concerns not listed above

PEER RELATIONS

How do you consider yourself socially: \_\_\_outgoing \_\_\_\_shy \_\_\_\_depends on the situation.

Are you happy with the amount of friends you have? (Y/N)

Have you ever been bullied? (Y/N)

Are your parents happy with your friends? (Y/N)

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

SCHOOL HISTORY

Do you like school? (Y/N)

Do you attend regularly? (Y/N)

What are your current grades?

Do you feel you are doing the best you can at school? (Y/N)

Is there anything else you would like me to know:

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: \_\_\_\_\_\_\_\_\_\_\_

Mother’s/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Contact:

Mother’s/Guardian’s Physical Address:

Mother’s/Guardian’s Mailing Address:

Father’s/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Contact:

Father’s/Guardian’s Physical Address:

Father’s/Guardian’s Mailing Address:

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name

Relationship (parent, sibling, etc)

Age

Sex

Type (bio, step, etc)

Living with you? Y/N

(If additional space is need please list on the back of 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?

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? Y/N

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

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N

If so, please describe:

CHILD’S DEVELOPMENT

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:

Did your child experience any developmental delays (e.g. toilet training, walking, 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:

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N)

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? (Y/N)

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

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

Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Ethnic Origin:

Total years of education completed: \_\_\_\_\_\_\_\_\_\_\_\_ Occupation:

Place of Employment:

Military experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_ Combat experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Assessment of current relationship if applicable: Poor\_\_\_\_\_ Fair\_\_\_\_\_\_\_ Good\_\_\_\_\_\_\_\_\_

Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Ethnic Origin:

Total years of education completed: Occupation:

Place of Employment:

Military experience? Y/N Combat experience? Y/N

Assessment of current relationship if applicable: Poor\_\_\_Fair\_\_\_ Good\_\_\_

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 at time of divorce?

If divorced, How much time does your child spend with each parent?

Mother\_\_\_\_\_%, Father \_\_\_\_\_%

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 or Drug use
* Lack of honesty Trauma
* Medical Concerns Infidelity (couple)
* Education problems Divorce/separation
* Financial problems Issues regarding remarriage
* Death of a family member Birth of a child
* Inadequate health insurance Job change or job dissatisfaction
* Inadequate housing/feeling unsafe
* Other

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

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)

Is there anything else you would like me to know: