ADOLESCENT INTAKE FORM

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 the first therapy session.

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-9

CLIENT INFORMATION

Name: _____
Date of Birth: _____ Age: _____ Gender:_____
Phone (Cell): _____Can we leave messages at this number?_____
School: _____Grade: _____

CURRENT REASON FOR SEEKING THERAPY

Why are you coming to therapy?

_____
_____

How do you think therapy might help you?

_____
_____

PERSONAL STRENGTHS

What activities do you enjoy?

_____
_____

What qualities are you proud to share with others? (e.g. kindness, intelligence)

_____
_____
_____

THERAPY/TREATMENT HISTORY

Have you previously seen a therapist? ❒ Yes ❒ No
If yes, what did you find **most helpful** in therapy?

_____
_____

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

_____
_____

SUBSTANCE 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 **often** do you smoke/chew? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

Do you currently use any other drugs? ❒ Yes ❒ No If yes, what kind?

_____

If yes, how often do you use? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

FAMILY INFORMATION

Are your parents married, divorced or separated? _____

Do you think their relationship is good? ❒ Yes ❒ No ❒ Unsure

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

Were you adopted? ❒ Yes ❒ No

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 ❒ 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

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? ❒ Yes ❒ No

Have you ever been bullied? ❒ Yes ❒ No If yes, please describe: _____

Are your parents happy with your friends? ❒ Yes ❒ No

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

_____

SCHOOL HISTORY

On a scale of 1-10 (10 being the most) how much do you enjoy school? _____

Do you attend regularly? ❒ Yes ❒ No

Generally, how are your grades? _____

Have there been any significant changes in your grades? ❒ Yes ❒ No

Do you feel you are doing the best you can at school? ❒ Yes ❒ No ❒ Unsure

INDIVIDUAL CONCERNS

Is there anything else you would like to share?

_____

_____

_____

Please place a checkmark in the appropriate box for each of the following that you might be feeling:

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					SOCIAL ISOLATION				
CRYING					PARANOID THOUGHTS				
PROBLEMS AT HOME					INDECISIVENESS				
HYPERACTIVITY					LOW ENERGY				
BINGING/PURGING					EXCESSIVE WORRY				
LONELINESS					POOR CONCENTRATION				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/INDIGESTIO N					IDENTITY QUESTIONS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF HARM/CUTTING					RACING THOUGHTS				
IMPULSIVITY					RESTLESSNESS				
NIGHTMARES					DRUG USE				
HOPELESSNESS					ALCOHOL USE				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
ANOREXIA					OBSESSIVE THOUGHTS				
GRIEF					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
HEADACHES					FEELING PANICKY				
CHANGE IN WEIGHT					SUICIDAL THOUGHTS				
CHANGE IN APPETITE					HOMICIDAL THOUGHTS				
DIFFICULTY SLEEPING					OTHER				

ADOLESCENT INTAKE FORM
PARENT SECTION

Parent(s) Name(s): _____
Parent(s) Phone number(s)_____
Adolescent's Name: _____Adolescent's Date of Birth: _____
Race/Ethnic Origin: _____

PRESENTING ISSUES

Briefly describe the presenting issue(s) for which you are seeking therapy for your adolescent.

_____
_____

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

_____
_____

What is most concerning right now?

_____
_____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?
❒ Yes ❒ No *If yes, please describe:*

_____
_____

Did your child have health problems at birth? ❒ Yes ❒ No *If yes, please describe:*

_____
_____

Has your child experienced any developmental delays (e.g. toilet training, walking, talking)?
❒ Yes ❒ No ❒ Unsure *If yes, please describe:*

_____
_____

Did your child display any developmentally unusual behaviors or problems prior to age 3?
❒ Yes ❒ No ❒ Unsure *If yes, please describe:*

_____
_____

Has your child experienced emotional, physical, or sexual trauma?
❒ Yes ❒ No ❒ Unsure *If yes, please describe:*

_____
_____

TREATMENT/MEDICAL HISTORY

Has your child previously seen a therapist ? ❒ Yes ❒ No *If yes, where:* _____
Approximate dates of counseling: _____
For what reason(s) did your child attend therapy? _____
Has your child accessed psychiatric services? ❒ Yes ❒ No *If yes, where:* _____
Has your child been treated at a higher level of care for mental health reasons? (e.g. inpatient, residential, partial, intensive outpatient program?)_____
Does your child have a previous mental health diagnosis? ❒ Yes ❒ No ❒ Unsure
If yes, please specify:
_____

What did you find **most helpful** about their treatment?
_____
_____
What did you find **least helpful** about their treatment?
_____
_____

Has your child taken medication for a **mental health** concern? ❒ Yes ❒ No
If yes, please indicate names, dosages, and dates:
_____
_____

Does your child have other **medical** concerns or previous hospitalizations? ❒ Yes ❒ No
If yes, please describe.
_____
_____

SUBSTANCE 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 child 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, your family, or your child (at present, or have had a significant effect in the past).
_____
_____
_____

SCHOOL HISTORY

Do you have any current concerns relating to your child's education? ❒ Yes ❒ No
If yes, please explain your concern:

_____
_____

Does your child receive special education services through their school system? ❒ Yes ❒ No
❒ IEP ❒ 504 Plan ❒ Speech ❒ OT ❒ PT

FAMILY HISTORY

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

_____
_____
_____

Did either parent experience any abuse/trauma in their **adult** life (physical, verbal, emotional, or sexual)? *Please describe as much as you feel comfortable.*

_____
_____

Please list all of the people in what you would describe as your immediate family:

NAME	RELATIONSHIP TO CHILD	AGE	GENDER	TYPE (BIO, STEP, ADOPTIVE)	LIVING WITH CHILD? Y/N

PARENT'S MARITAL STATUS *(This question refers to the parents relationship. 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, if applicable.)*

❒ Single ❒ Married (legally) ❒ Divorced ❒ Co-habitating ❒ Divorce in process ❒ Separated
❒ Widower ❒ Remarried (mother) ❒ Remarried (father) ❒ Other
Length of marriage/relationship:_____
If divorced, how old was your child at time of divorce? _____

Parent's Name: _____Birth Date:_____ Age: _____
Ethnic Origin: _____
Occupation: _____Place of Employment: _____
Military experience? ❒ Yes ❒ No
Current Status ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Other
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Parent's Name: _____Birth Date:_____ Age: _____
Ethnic Origin: _____
Occupation: _____Plac of Employment: _____
Military experience? ❒ Yes ❒ No
Current Status ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Other
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Please note any custody concerns/arrangements if applicable:
_____
_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to your child (e.g. father, maternal grandmother, uncle, etc.)

❒ Alcohol/substance abuse ❒ Anxiety ❒ Depression ❒ Domestic Violence
❒ Eating disorders ❒ Obsessive compulsive behavior ❒ Major mental illness ❒ Suicide attempts ❒ Psychiatric hospitalizations ❒ Other _____
List family member(s): _____

FAMILY CONCERNS (*Please check any family concerns that your family is <u>currently</u> experiencing*)
❒ Fighting ❒ Disagreeing about relatives ❒ Feeling distant ❒ Disagreeing about friends
❒ Loss of fun ❒ Alcohol use ❒ Lack of honesty ❒ Drug use ❒ Physical fights ❒ 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
Other concerns not listed above:
_____
_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your child enjoys?

_____

_____

What positive personal qualities does your child have?

_____

_____

Who are some of the influential and supportive people, activities or beliefs in your child's life?
Please describe:

_____

_____

Is there anything else you would like to share?

_____

_____

_____

Please place a checkmark in the appropriate box for each of the following symptom that is affecting your adolescent:

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					SOCIAL ISOLATION				
CRYING					PARANOID THOUGHTS				
PROBLEMS AT HOME					INDECISIVENESS				
HYPERACTIVITY					LOW ENERGY				
BINGING/PURGING					EXCESSIVE WORRY				
LONELINESS					POOR CONCENTRATION				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/INDIGESTION					IDENTITY QUESTIONS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF HARM/CUTTING					RACING THOUGHTS				
IMPULSIVITY					RESTLESSNESS				
NIGHTMARES					DRUG USE				
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HEADACHES					FEELING PANICKY				
CHANGE IN WEIGHT					SUICIDAL THOUGHTS				
CHANGE IN APPETITE					HOMICIDAL THOUGHTS				
DIFFICULTY SLEEPING					OTHER				

Special Confidentiality Notice for Parents

We strongly believe that for therapy to be helpful to an adolescent, there needs to be as much confidentiality for them as possible in the therapy process. That is, unless the issue falls into the following categories…

--your child is clearly unsafe or at risk of harming themselves
--your child is at risk of being harmed by anyone else
--your child is at risk of harming someone else
--we are required by a court to disclose treatment records

…in which case we would follow the clinically and legally appropriate reporting requirements. Outside of this, we will encourage your child to express themselves freely, and assure them that there will be confidentiality provided to them in this process. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is facing, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you, and we are happy to facilitate family meetings whenever helpful and appropriate.