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Adolescent Intake

Client Name:___________________________________ Today's Date:____________________

Age:________________________________ Date of Birth: ______________________________

Parent(s)/Guardian(s):____

Home Address: ____

Mailing Address: ____

Home Phone: _______________________Client's Cell Phone: __________________________

Parent's Cell Phone: ____________________Parent's Work Phone: _______________________

Parent's Email Address: ____

Parent's Occupation: _________________________ Employer: _________________________

Whom do you live with? Name Age

Parent(s)Guardian(s): ____

Sibling(s): ____

____

____

____

Other: ____

Concerns about your child that bring you to therapy:

____

____

____

When did your child's current symptoms first appear?

____

First date of same or similar symptoms in the past:

____

Goals for therapy: (What would you like your child to accomplish in therapy?)

____

____

____

Does the family have a Spiritual Practice or Church Connection? (Please Describe):

____

____

ADOLESCENT HEALTH CARE INFORMATION AND MEDICAL HISTORY:

Prior hospitalizations or major surgeries (include year): ___________________________________

____

Serious illnesses/injuries/allergies: ____

Current medications (name & dosage): ____

____

Does your child smoke cigarettes? Y N How often? ______________________________

Does your child drink alcohol? Y N How much? _________________________________

Other drug use? Y N Type and amount/frequency? ______________________________

Is your child sexually active? Y N Since what age? ____________________________

Family Medical History (please list any major health problems or alcohol/drug problems of any immediate or extended family members, and indicate relationship of the person to your child):

____

____

____

MENTAL HEALTH HISTORY:

Has your child had prior therapy? Y N When? _____________________________

Length of Therapy (months/years) ________________ Purpose of Therapy? ________________

____

Was the therapy helpful and if so how? ____

____

Has your child ever been given a mental health diagnosis? Y N Please list and state if you agree with the diagnosis:

____

Prior/Present suicidal thoughts or attempts? Y N If so, when __________________________

Prior/present thoughts or attempts to harm self or others? Y N If so, explain _____________

____

Has your child ever been hospitalized for mental health reasons? Y N If so, when/where/why:

____

Family Mental Health History (please list any mental health problems/diagnoses or suicidal attempts you are aware of for any immediate or extended family members of the child, and indicate relationship of the person to the child):

____

____

PROBLEMS YOU FEEL APPLY TO YOUR CHILD (Please check those that apply to you and explain when indicated):

___ Abandonment
___ Abuse (explain: ___________________)
___ Affair (explain: _____________________)
___ Alcohol
___ Alienation
___ Anger
___ Anxiety
___ Avoidant
___ Appetite (increase ___ decrease ___)
___ Blended Family
___ Body Image
___ Bonding
___ Boundaries
___ Codependency
___ Communication
___ Compulsive Eating
___ Compulsions
___ Concentration
___ Crisis (explain: ______________________)
___ Depression
___ Disability (explain: ___________________)
___ Distractible
___ Distressing Dreams
___ Distressing Memories
___ Divorce
___Domestic Violence (actual or threatened)
___ Drugs
___ Eating Disorder (explain: ____________)
___ Emotionally Numb
___ Employment (explain: ______________)
___ Emptiness
___ Enabling (explain: _________________)
___ Family Conflict (explain: ______________)
___ Fatigue/Low Energy

___ Fears (explain: ______________________)

___ Grief (explain: ________________________)

___ Hallucinations (visual or auditory)

___ Hyperactive

___ Inactivity

___ Impulsivity

___ Isolation

___ Legal Problem (explain: ________________)

___ Medical (explain: _____________________)

___ Mood Swings

___ Pain (explain: _________________________)

___ Rage

___ Rejection

___ Self Absorption

___ Sexual Abuse

___ Sibling Conflict

___ Sleep (explain: ________________________)

___ Financial Stress

___ Guilt (explain: ____________________)

___ Hopelessness

___ Idealizations

___ Inhibitions

___ Irritability

___ Jealousy

___ Marital

___ Memory Loss

___ Obsessions

___ Panic Attacks

___ Rationalizations

___ Relationships

___ Self-Esteem

___ Shame

___ Social Skills

___ Suicidal (Thoughts or Actions)

___ Trauma/Life Threatening Event (explain: ____)

___ Trust

___ Weight Change (explain: ____)

___ Worry

___ Other (explain: ____)

Thank-you for your willingness and time to provide this personal information

____ __________________________

Parent Signature Date