Inner Wisdom Counseling
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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 HISTROY:

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 often? _____

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 the relationship of that person to the child):

_____

_____

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

___ Abandonment
___Abuse (explain: _____)
___Alcohol
___Anger
___Anxiety
___Avoidant
___Appetite (increase ___ decrease ___)
___Blended Family
___Body Image
___Bonding
___Boundaries
___Communication
___Compulsive Eating
___Compulsions (explain: _____)
___Concentration
___Crisis (explain: _____)
___Depression
___Disability (explain: _____)
___Distractible
___Distressing Dreams
___Distressing Memories
___Drugs
___Eating Disorder (explain: _____)
___Emotionally Numb
___Family Violence (explain: _____)
___Fatigue/Low Energy
___Fears (list: _____)
___Grades
___Grief (explain: _____)
___Guilt (explain: _____)
___Hallucinations (visual or auditory)
___Hopelessness
___Hyperactive
___Inactivity
___Impulsivity
___Irritability
___Isolation
___Legal Problem (explain: _____)
___Medical (explain: _____)
___Memory Loss
___Mood Swings
___Obsessions
___Pain (explain: _____)
___Panic Attacks
___Rage
___Rationalizations
___Rejection
___Relationships
___School Problems
___Self Absorption
___Self-Esteem
___Sexual Abuse
___Shame
___Sibling Conflict
___Social Skills
___Sleep (explain: _____)
___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/Guardian Signature	Relationship to Client	Date