ADOLESCENT CLIENT INTAKE FORM

This form may seem long. But the information on it will help us to better help you. Anything you put on this form is confidential unless it has to do with someone hurting herself or himself or someone else.

Adolescent Information

Name: _____ Date of First Visit: _____

Address: _____ City, State, Zip: _____

Gender: _____Age: _____Date of Birth: _____ Email: _____

Home Phone: _____OK to Call? _____ OK to Leave Message? _____

Cell Phone: _____ OK to Call? _____ OK to Leave Message? _____

Parents or Legal Guardians: _____

With whom do you live? _____

Brought in for counseling by: _____ Relationship to you:_____

What school do you go to? _____Grade: _____

Are you here because you want counseling or because someone else wants you to get counseling?
I do: _____ Someone else does: _____

Check any of the symptoms that you are having:

Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	

(This space reserved for additional comments by clinician)

Feeling of extreme happiness		Problems getting along with friends or families	
Trouble going to school		Feeling stressed	
Lack of enjoyment of usual activities		Easily irritated	
Self-esteem problem		Feeling guilty	
Perfectionism		Feeling nervous	
Obsessions or compulsions		Sudden feelings of panic	
Feeling fearful		Muscle tension	
Physical complaints of pain		Acting violently	
Problems with anger		Thoughts about killing yourself or others	
Thoughts about hurting yourself or others			

Family Information

Your biological parents' names and ages:

_____

_____

Adults with whom you live:

_____

_____

List names and ages of biological brothers and sisters:

_____

_____

List names and ages of stepbrothers and sisters and other children living in the home:

_____

_____

Were you adopted? Yes _____ No _____

If yes, at what age: _____

Have you ever lived in foster care or a similar living arrangement? Yes _____ No _____
If yes, at what age(s): _____

Has there been a death of a family member? Yes _____ No _____
If yes, what relationship was this person to you? _____

History

Do you have problems sleeping? Yes _____ No _____
If yes, please describe: _____

Do you have any problems with eating? Yes _____ No _____
If yes, please describe: _____

Do you have any unusual fears? Yes _____ No _____
If yes, please describe: _____

Have you ever had any major illnesses or injuries? Yes _____ No _____
If yes, please describe: _____

Have there been any critical events in your life? Yes _____ No _____
If yes, please describe: _____

Have you ever been sexually abused? Yes _____ No _____

Have you ever been physically abused? Yes _____ No _____

Have any of the other children in your home been abused? Yes _____ No _____

Have you ever witnessed violence between adults? Yes _____ No _____

How would you describe your interactions with kids your own age?

_____

_____

How would you describe your interactions with adults?

_____

_____

Have you gone through periods of major stress? Yes _____ No _____

Are you using alcohol or other drugs? Yes _____ No _____

If yes, please list:
_____

Are you sexually active? Yes _____ No _____

Have you done any behavior that has legal implications? Yes _____ No_____
(shoplifting ,tagging, etc.)

Do you like to spend time on the internet? Yes _____ No_____

How well do you do in school?
_____

_____

How well are you doing with your home life?
_____

_____

Counseling and Medical Information

Have you been in counseling before? Yes _____ No _____

If yes, where and with whom? _____

How helpful was it? _____

Are you presently under any medical care for any illness? Yes _____ No _____

If yes, please describe: _____

Have you ever been hospitalized? Yes _____ No _____

If yes, please describe: _____

Are you taking any medications? Yes _____ No _____
If yes, please list:
_____

Has anyone in your family been diagnosed with a mental illness? Yes _____ No _____

Has anyone in your family had a problem with alcohol or other drugs? Yes _____ No _____

How do you feel about becoming involved in counseling?

Briefly state your goals for counseling:

Is there anything else I need to know at this time?