ADOLESCENT INTAKE – *To be filled out by Parent or Guardian*

Parent/Guardian Information

Name: ______________________________ Date: ______________

Home Address: ______________________________ City/State/Zip: ______________

Home Phone: ______________________________ Work Phone: ______________

Cell Phone: ______________________________ Email: ______________

May I call and leave messages at home? ◻ Yes ◻ No Work? ◻ Yes ◻ No Cell Phone? ◻ Yes ◻ No

Marital Status: ◻ S ◻ M ◻ D ◻ W No. of Marriages: __________ Date of Current Divorce/Sep. ______________

If Divorced, Name of Other Custodial Parent: ______________________________ Phone: ______________

Occupation: ______________________________ Highest Level of Education: ______________

Children(s) Name(s): ______________________________ DOB: ______________ ◻ M ◻ F

______________________________ DOB: ______________ ◻ M ◻ F

______________________________ DOB: ______________ ◻ M ◻ F

______________________________ DOB: ______________ ◻ M ◻ F

How much contact per week do you have with the adolescent coming for treatment? ______________

Client Information (Adolescent Coming For Treatment)

Name of Client: ______________________________ DOB: ______________

The Client is Currently Living With: ______________________________ School and Grade: ______________

Extracurricular Activities/Interests: ______________________________

Medical History

How would you rate the client's current physical health? ◻Excellent ◻ Good ◻ Fair ◻ Poor

Is the client currently complaining of any physical problems? If Yes, Please Explain: ______________

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Please list any medical conditions/disabilities/learning disabilities: ______________________________

Daily Medication(s) Over the Counter or Prescription	Prescribing Physician

Pediatrician/Family Physician: ______________________________ Phone: ______________

Counseling and Psychiatric History

Has the client had previous counseling? ◻ Yes ◻ No If yes, for how long? ______________ When? __________

For what reason? ______________________________ Name of Counselor: ______________

Has the client ever been diagnosed or treated for any type of mental illness? If yes, what type? ______________________

Has anyone in the family ever been diagnosed with or treated for any type of mental illness? If yes, what type? ______________

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Reasons for Seeking Help

What concerns about the client have brought you to counseling today? ______________________________

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Where are these concerns causing the most problems? □ Home □ School □ Social □ Other

When did these concerns begin to be a problem? ______________________________

What concerns about have been identified by others? ______________________________

Please indicate which of the following are currently problems for the adolescent:

□ Crying Spells
□ Excessive Fear/Anxiety
□ Bullying/Picking Fights
□ Hearing Voices
□ Lack of Motivation
□ Decreased/Increased Appetite
□ Difficulty Making or Keeping Friends
□ Obsessions/Compulsions
□ Cutting

□ Hyperactivity
□ Refusal to Respond to Authority
□ Nightmares
□ Difficulty Separating from Specific Family Members
□ Tantrums
□ Lack of Self-Confidence
□ Loss of Interest in Usual Activities
□ Insomnia/Hypersomnia

Is there anything else that you would like for me to know today? ______________________________

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How did you hear about our counseling office? ______________________________

Emergency Contact*– Name: ______________________ **Phone:** ______________

Relationship to the Child: ______________________________

***This person will only be contacted if there is a counseling related emergency and you (or the primary guardian) cannot be reached. Please discuss any concerns or questions you have about this with me.**