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.**