Adolescent Intake Form

Please answer all information as completely as possible. Information given is strictly confidential and beneficial in providing the best possible service. Feel free to ask for assistance, if needed. Your counselor will discuss your responses with you in your interview.

Name: ____ Today's Date: ____________

Parent/Legal Guardian Name: ____

(If the child is not living with both natural parents, both adoptive parents, or only living parent, the center requires a photocopy of the legal document stating custody arrangements, consisting of the cover page, page specifying conservator(s), and signature page, stapled to this form.)

Home Address: ____ (May receive mail: yes/no)

City: _______________________________ State: ____________ Zip: ___________

Home Phone: _________________________________ (May call: yes/no; May leave message: yes/no)

Work Phone: __________________________________ (May call yes/no; May leave message: yes/no)

Cell Phone: ___________________________________ (May call yes/no; May leave message: yes/no)

Would you like to receive a discreet phone call to remind you of your appointment 24 hours in advance?

☐Yes ☐No If, yes, I prefer the following telephone number to be used: ☐ Home ☐ Work ☐ Cell

Email Address: ____ (May email: yes/no)

Can we email you our newsletter or information about any upcoming seminars? ☐Yes ☐No

Date of Birth: __________________ Age: ___________ Gender: ☐Male ☐Female

School: _____________________________________ Grade: _______

School Counselor: ____

Name of Person(s) to contact in case of Emergency:

1. ____ Phone: _______________________
2. ____ Phone: _______________________

Briefly describe your reason for seeking help: ____

____

How did you hear about us? ____

Immediate Family Members (parents, siblings) *Family of Origin* (extended family)

Name	Age	Relationship	Name	Age	Relationship

Does anyone in your family suffer from alcoholism, and eating disorder, depression or anything that might be considered a mental disorder? Please explain: ____

____

MEDICAL INFORMATION

Primary Care Physician: Name ____

Address __________________________________ Phone ___________________

How would you rate your current physical health? ☐Excellent ☐Good ☐Fair ☐Poor

Are you currently experiencing any physical problems (e.g. headaches, body aches) ☐Yes ☐No

If yes, please explain: ____

____

Please circle the following items for which a diagnosis has been given: Depression, ADHD-Hyperactive, ADHD-Inattentive, Conduct Disorder, Learning Disability, Anxiety/Nervousness, Panic Attacks, Bipolar, Schizophrenia, Oppositional Defiant Disorder, Mood/Anger, Tics, Insomnia/Sleeplessness, Obsessive/Compulsive, Addictions, Post Traumatic Stress Disorder, Other: _______________________________________

List medications you are currently taking:

Medication: ______________________________________ Dosage: ___________

Medication: ______________________________________ Dosage: ___________

Medication: ______________________________________ Dosage: ___________

Medication: ______________________________________ Dosage: ___________

*List current illnesses or disabilities:*____

____

____

Past/current suicidal or homicidal thoughts/attempts? Please explain briefly.

____

____

____

Physical/sexual abuse? Please explain briefly.

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____

____

Have you ever seen a mental health professional (psychiatrist, psychologist, or counselor)? ☐No ☐Yes

If so, do you feel it would be helpful for your counselor to speak with that person? ☐No ☐Yes

Previous Mental Health Professional/Agency: ____

Phone: ____________________ Dates of Service: from ____/____ to ___/____

Have you ever been hospitalized for mental health concerns? ☐No ☐Yes

If yes, please explain briefly (include hospital, doctor's name and dates): ________________________

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____

CURRENT CONCERNS

- ☐ Abuse (physical, emotional, sexual)
- ☐ Abuse of non-prescription drugs
- ☐ Adjustment to life changes (job change, move, marriage)
- ☐ Anger
- ☐ Anxious (nervous, clingy, fearful, worried)
- ☐ Behavior problems
- ☐ Being a parent
- ☐ Binge/Vomit/Laxatives
- ☐ Blackouts or temporary loss of memory
- ☐ Bowel disturbances
- ☐ Career choices
- ☐ Children having problems
- ☐ Compulsive behavior
- ☐ Crying spells
- ☐ Depressed
- ☐ Difficulty having fun
- ☐ Difficulty making friends
- ☐ Disturbing memories (past abuse, neglect or other)
- ☐ Divorce
- ☐ Dizziness
- ☐ Drugs
- ☐ Easily distracted
- ☐ Education
- ☐ Excessive boredom
- ☐ Fainting spells
- ☐ Family or Step-family relationships
- ☐ Fatigue
- ☐ Feel lonely
- ☐ Feel panicky
- ☐ Feeling "numb" or cut off from emotions
- ☐ Feeling "on top of the world"
- ☐ Feeling ashamed
- ☐ Feeling distant from God
- ☐ Feeling fat
- ☐ Feeling guilt
- ☐ Feeling of inferiority
- ☐ Financial problems
- ☐ Health concerns
- ☐ Hearing voices
- ☐ Hyperactive
- ☐ Inability to control thoughts
- ☐ Insomnia (unable to sleep)
- ☐ Lack of motivation
- ☐ Learning/Academic difficulties
- ☐ Legal matters
- ☐ Lose time
- ☐ Loss of interest in sex
- ☐ Memory
- ☐ Nightmares
- ☐ No appetite
- ☐ Non-family relationship problems
- ☐ Palpitations
- ☐ Parent/child relationship problems
- ☐ Poor home environment
- ☐ Problem with alcohol
- ☐ Religious/Spiritual concerns
- ☐ Self-control
- ☐ Sexual identity concerns
- ☐ Sexual problems
- ☐ Sleeping all the time
- ☐ Spouse problems
- ☐ Suicidal urges
- ☐ Suspicious of other people
- ☐ Take sedatives
- ☐ Tense feelings
- ☐ Thoughts of suicide
- ☐ Tremors
- ☐ Unable to relax
- ☐ Unable to sit still
- ☐ Other ____