**ADOLESCENT INTAKE FORM**

**FAMILY DEMOGRAPHICS**

Client Name: Today’s Date:

Date of Birth: Age:

Address: City, State, Zip:

Telephone: Email:

Current School: Grade:

May I leave messages for you at any phone number listed: Yes No

Do you live alone or with others?

If you live with others, please list them below:

|  |  |
| --- | --- |
| Name:  Age:  Relationship: | Name:  Age:  Relationship: |
| Name:  Age:  Relationship: | Name:  Age:  Relationship: |

Emergency contact:

Phone: Relationship:

Referred by:

**STRENGTHS AND CONCERNS**

What are your strengths? What is going well in your life?

What are your hobbies and interests? What are you good at?

How do you do in school, academically and socially?

Please describe the concerns that brought you here today:

When did the concerns begin?

How are your relationships with family members, including your parents or caregivers?

**PLEASE CHECK ANY OF THE BELOW SYMPTOMS YOU ARE EXPERIENCING:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Depression |  | Feeling of extreme happiness |
|  | Extreme sadness |  | School Problems |
|  | Trouble concentrating |  | Problems getting along with friends or family |
|  | Memory problems |  | Cold / Flu |
|  | Feeling hopeless |  | Injuries |
|  | Lack of energy |  | Chronic Health Conditions |
|  | Feeling tearful |  | Physical complaints of pain |
|  | Lack of enjoyment of usual activities |  | Bed Wetting |
|  | Change in eating habits |  | Disordered Eating |
|  | Change in sleeping habits |  | Weight changes |
|  | Loss or Grief |  | Substance Abuse |
|  | Perfectionism |  | Feeling stressed |
|  | Feeling fearful |  | Easily irritated |
|  | Feeling guilty |  | Problems with anger |
|  | Feeling nervous |  | Acting violently |
|  | Obsessions or compulsions |  | Legal Problems |
|  | Sudden feelings of panic |  | Thoughts of hurting self or others |
|  | Low Self Esteem |  | Thoughts of killing self or others |

**SUBSTANCE ABUSE HISTORY**

Please describe any current or past use of:

Tobacco (any form)?

Alcohol?

Caffeine (any form)?

Mind-altering substances (drugs)?

**MEDICAL INFORMATION**

Do you have any allergies?

Do you have any current or past diagnoses?

Please list any medications you are taking below:

|  |  |
| --- | --- |
| MEDICATION | DOSAGE |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |
| 5. |  |

**COUNSELING HISTORY**

Have you ever been to counseling before? Yes No

If so, please describe each counseling experience below (most recent first):

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes:

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes:

1. Provider’s name:

Dates of service:

Explanation of concerns and outcomes: