Adolescent Intake Form for ages 13 through 17

Welcome! Please complete this form so we can better understand your situation.

Client's Full Legal Name: _____ Date of Birth: _____

Name of person completing this form and relationship to client: _____

Contact Information of Parent(s) or Legal Guardian(s):

Client's Primary Residence: _____

- OK to send mail to the above address? Yes No *(please circle one)*

Owner of Residence: _____

Client's Primary Phone Number: (_____)_____ *(please circle one):* Cell Home Work

Name of Primary Phone Owner: _____ Relationship to Client: _____

- OK to leave voice messages? Yes No *(please circle one)* OK to text? Yes No *(please circle one)*

Secondary Phone Number: (_____)_____ *(please circle one):* Cell Home Work

Name of Secondary Phone Owner: _____ Relationship to Client: _____

- OK to leave voice messages? Yes No *(please circle one)* OK to text? Yes No *(please circle one)*

Email Address of Parent or Legal Guardian: _____

- OK to communicate through email? Yes No *(please circle one)*

Insurance Information:

Primary Insurance ID or Contract#_____ Group #_____

Name of Insurance: _____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

PO Box for claims *(on the back of the card):* _____

Secondary Insurance ID or Contract#_____ Group #_____

Name of Secondary Insurance: _____

Subscriber *(who holds the policy):* _____ Subscriber's DOB: _____

PO Box for claims *(on the back of the card):* _____

What is the primary concern to be addressed for the child in counseling? _____

_____

Has the child had any mental/behavioral health treatment in the past? If so, when and where? Please explain:

_____

_____

Personal Information and History:

Please indicate which of the following the child has experienced in the last two years with an X or check mark:

___ Temper tantrums
___ Lies frequently
___ Angry or easily irritable
___ Pregnancy
___ Crying frequently
___ Parent's separation/divorce
__ Distorted body image
__ Problems with pornography
__ Gender identity issues
__ Difficulty with discipline
__ Parent's separation/divorce
__ Significant weight gain/loss
___ Feeling hopeless or worthless
___ Suicidal or self-harm thoughts
___ Cutting or self-harm
___ Suicide attempt(s)
___ Inappropriate sexual behavior
___ Extreme risk taking behavior
__ Hates or fears going to school
__ Problems learning in school
__ Poor grades/performing under their ability
__ Problems with family relationships
__ Speech concerns
___ Anxiety or panic attacks
___ Avoiding going anywhere
___ Victim of bullying
___ Needs a lot of reminders
___ Concentration issues
___ Rapid mood changes
__ Excessive perfectionism
__ Complaints of ache/pain
__ Death in the family
__ Moved (relocated home)
__ Eating concerns

___ Substance exposure: ___ Alcohol ___ Hallucinogens ___ Marijuana/Cannabis __ Unsure
___ Opiates/Opioids ___ Stimulants ___ Sedative/Hypnotics
__ Other: _____

Race and Ethnicity (optional):

___ American Indian or Alaska Native
___ Asian American or Asian
___ African American or Black
___ European American or White
___ Hispanic
___ Pacific Islander
___ Two or More Races
___ Other: _____

Education Status: Grade level: _____

___ Alternative school
___ Home school
___ Private school
___ Public school
___ Not in school/dropped out
___ Unknown
___ Other (please explain) _____

Employment Status:

___ Full Time (30+ hours)
___ Part Time (less than 30 hours)
___ Volunteer
___ Stay at home parent
___ Unemployed

Sexual Orientation (optional): _____ ___ Unsure
With which gender does the child identify? ___ Female ___ Male ___ Other ___ Unsure
If Other, please specify: _____

Spirituality (optional):

Religious affiliation? Yes No *(circle one)* If yes: _____ ___ Unsure

Legal History:

Any involvement with the legal system? Yes No *(circle one)* If yes, arrests or pending charges? Yes No *(circle one)*
Current probation? Yes No *(circle one)* Name of Officer: _____
If yes to any of the above, please explain:

_____

_____

Substance Abuse History:

Does the child drink alcohol? ☐ Daily use ☐ Occasional Use ☐ None ☐ Unknown
Does the child use tobacco? ☐ Daily use ☐ Occasional Use ☐ None ☐ Unknown
Does the child use drugs? ☐ Daily use ☐ Occasional Use ☐ None ☐ Unknown

Child's Family and/or Supportive Relationships. Please list parent(s) or legal guardian(s) first: **Living with child?** (circle one)

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Name: _____ Age: _____ Relationship: _____ Yes No

Birth and Early Development History:

Is the child adopted? Yes No *(circle one)* If yes, at what age? _____

Are there any known complications with the pregnancy or birth of the child? Please explain: _____

_____

Are there any known complications or significant problems in the first few years of the child's life? _____

_____

Trauma History: *(please circle one)* If yes, when? Please include any information you feel is important.

Emotional Yes No _____

Neglect Yes No _____

Physical Yes No _____

Sexual Yes No _____

Verbal Yes No _____

Medical History:

Has the child had any medical procedures? Yes No *(circle one)* If yes, please explain: _____

_____

_____

Medical Conditions and Diagnosis:

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

_____ When DX: _____ Treatment: _____

Please list current medications and what they are taken for:

Name of medication, dose (mg, ml, sublingual, etc.), and frequency — What is it intended for?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please attach another page if necessary.

Obstetrical History:

Please list number of the following:

Pregnancies ____ Full-Term____ Pre-Term____ Abortions____ Miscarriages____
Tubal Pregnancies____ Multiples____ Living Children____ Stillbirths ____

Any additional information for your treating provider? _____

_____

_____

Thank you for taking time to complete this form.

Signature: _____ Date: _____

Signature of Treating Provider: _____