Adolescent Intake Form for ages 13 through 17

Client's Full Legal Name: ____ Date of Birth: _________________________

Name of person completing this form: _________________________ 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

Name of Insurance: ____

Member/Enrollee ID or Contract#______________________________________ Group #____________________________

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

Subscriber's Address: ____

Secondary Insurance (if applicable)

Name of Insurance: ____

Member/Enrollee ID or Contract#______________________________________ Group #____________________________

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

Subscriber's Address: ____

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
___ Opiates/Opioids
___ Marijuana/Cannabis
___ Stimulants
__ Unsure
___ Sedative/Hypnotics
___Other: ____

Race and Ethnicity (optional):
___ American Indian or Alaska Native
___ European American or White
___ Two or More Races
___ Asian American or Asian
___ Hispanic
___ Other: ____________________________________
___ African American or Black
___ Pacific Islander

Education Status: Grade level: _________
___ Alternative school
___ Public school
___ Home school
___ Not in school/dropped out
___ Private school
___ Unknown
___ Other (please explain) ____

Employment Status of parent/guardian(s):
___ 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

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____

Any additional information for your treating provider? ____

____

____

____

Thank you for taking time to complete this form.

Client, Parent or Legal Guardian Signature: ______________________________________ Date: __________________

Signature of Treating Provider: ____