

Adolescent Intake Form for ages 13 through 17

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

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:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Temper tantrums | <input type="checkbox"/> Feeling hopeless or worthless | <input type="checkbox"/> Anxiety or panic attacks | |
| <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Suicidal or self-harm thoughts | <input type="checkbox"/> Avoiding going anywhere | |
| <input type="checkbox"/> Angry or easily irritable | <input type="checkbox"/> Cutting or self-harm | <input type="checkbox"/> Victim of bullying | |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Suicide attempt(s) | <input type="checkbox"/> Needs a lot of reminders | |
| <input type="checkbox"/> Crying frequently | <input type="checkbox"/> Inappropriate sexual behavior | <input type="checkbox"/> Concentration issues | |
| <input type="checkbox"/> Parent's separation/divorce | <input type="checkbox"/> Extreme risk taking behavior | <input type="checkbox"/> Rapid mood changes | |
| <input type="checkbox"/> Distorted body image | <input type="checkbox"/> Hates or fears going to school | <input type="checkbox"/> Excessive perfectionism | |
| <input type="checkbox"/> Problems with pornography | <input type="checkbox"/> Problems learning in school | <input type="checkbox"/> Complaints of ache/pain | |
| <input type="checkbox"/> Gender identity issues | <input type="checkbox"/> Poor grades/performing under their ability | <input type="checkbox"/> Death in the family | |
| <input type="checkbox"/> Difficulty with discipline | <input type="checkbox"/> Problems with family relationships | <input type="checkbox"/> Moved (relocated home) | |
| <input type="checkbox"/> Parent's separation/divorce | <input type="checkbox"/> Speech concerns | <input type="checkbox"/> Eating concerns | |
| <input type="checkbox"/> Significant weight gain/loss | | | |
| <input type="checkbox"/> Substance exposure: | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Marijuana/Cannabis |
| <input type="checkbox"/> Unsure | | | |
| | <input type="checkbox"/> Opiates/Opioids | <input type="checkbox"/> Stimulants | <input type="checkbox"/> Sedative/Hypnotics |
| | <input type="checkbox"/> Other: _____ | | |

Race and Ethnicity (optional):

- | | | |
|---|--|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian American or Asian | <input type="checkbox"/> African American or Black |
| <input type="checkbox"/> European American or White | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Two or More Races | <input type="checkbox"/> Other: _____ | |

Education Status: Grade level: _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Alternative school | <input type="checkbox"/> Home school | <input type="checkbox"/> Private school |
| <input type="checkbox"/> Public school | <input type="checkbox"/> Not in school/dropped out | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other (please explain) _____ | | |

Employment Status:

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Full Time (30+ hours) | <input type="checkbox"/> Part Time (less than 30 hours) | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Stay at home parent | <input type="checkbox"/> 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)	
			Yes	No
Name: _____	Age: _____	Relationship: _____		
Name: _____	Age: _____	Relationship: _____		
Name: _____	Age: _____	Relationship: _____		
Name: _____	Age: _____	Relationship: _____		
Name: _____	Age: _____	Relationship: _____		
Name: _____	Age: _____	Relationship: _____		
Name: _____	Age: _____	Relationship: _____		

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: _____