

ADOLESCENT CLIENT INTAKE

Name _____ Nickname _____
Date of Birth _____ Age _____ Sex _____ Date of First Appt. _____

Please state your reason for coming today.

What are some ways you have attempted to deal with this problem(s) so far, or in the past?

FAMILY MEDICAL & SOCIAL HISTORY:

Please write down any medications you are currently taking:

- 1) _____ Dosage/Freq. _____ Start Date _____ Purpose _____
- 2) _____ Dosage/Freq. _____ Start Date _____ Purpose _____
- 3) _____ Dosage/Freq. _____ Start Date _____ Purpose _____
- 4) _____ Dosage/Freq. _____ Start Date _____ Purpose _____

Prescribed

by _____

Name of your doctor: _____

Have you ever been hospitalized for physical or emotional concerns? YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

Have you ever been in counseling before? YES NO If yes, please state when and reason and if you found it helpful: _____

Do you use recreational drugs: YES NO If no: have you used previously? YES NO
If yes, when did you stop? _____

If yes, please list:

Type of Drug	How Much	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol: YES NO If no: have you drank previously? YES NO
If yes: when did you stop? _____

If yes, please list:

Type of Alcohol	How Much	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes: YES NO

Do you ever eat to the point of feeling sick?

very fequently frequently fairly often
occasionally rarely never

Do you use laxative or suppositories to hlep control your weight?

once a day once or twice a week 3-6 times a week
2-3 times a month once a month or less never

Describe any health problems you experience:

Do you have any close relative (father, mother, brother, sister) who have experienced depression, drug or alcohol use/abuse or other emotional problems? Please list: _____

SCHOOL & FAMILY HISTORY:

Are you experiencing any problems in school with the academics or peers or teachers? YES NO

If yes, please explain: _____

What school do you attend _____ What city _____

What year of school are you in or just completed? _____

What are your concerns about school, if any? _____

What do you like best about school? _____

What out of school programs are you involved in (church, music, sports, tutoring, other):

Have you ever been employed or done volunteer work? YES NO

If yes:

When _____ Are you working now? _____

With Whom _____

Doing What _____

Please check the information which applies to your parents:

Are they biological or adoptive parents? _____

MOTHER _____ living
_____ deceased
_____ married
_____ divorced
_____ remarried _____ #of times

FATHER _____ living
_____ deceased
_____ married
_____ divorced
_____ remarried _____
(#of times)

Do you consider someone else (stepparent, grandparent, etc) to be one or both of your "real" parents?

If so, who _____

Where do your parents live: Mother _____

Father _____

Describe your relationship with your mother: _____

What do you like best about her? _____

What do you most wish would be different? _____

Describe your relationship with your father: _____

What do you like best about him? _____

What do you most wish would be different? _____

What do you like most and least about living in your family? _____

List first names and ages of brothers & sisters, including yourself:

Name

Age

Relationship (Natural, step, half, etc)

Describe any family problems which occurred in the past or now, relating to: alcohol/drug abuse, sexual/physical/emotional abuse: _____

Others living in the home with you:

NAME RELATIONSHIP AGE GRADE/OCCUPATION

Please check any of the following that describe how you have been feeling or thinking in the last two months or related to the reason you are here:

sad worried all the time depressed frightened guilty angry ashamed
 aggressive resentful worthless tearful irritable confused
 extreme ups & downs jealous hopeless helpless poor concentration
 loss of interest in activities normally interesting or fun phobias repetitious acts
 unwanted thoughts headaches stomachaches nightmares
 I sometimes hear voices even though no one nearby is talking to me
 I sometimes feel that forces outside of me control me
 I sometimes feel that other people control my thoughts
 I sometimes feel that someone is out to hurt me or do something against me.
 I am sometimes unable to control my behavior; Please explain _____

Describe any other feelings you have had: _____

Have you had any change in sleeping habits? YES NO Describe _____

Have you had any change in your appetite? YES NO Describe _____

Has there been weight loss ___ or gain ___? How much? _____ In what time span? _____

Have you ever considered suicide in connection to your **current** problems? YES NO

If so, please give a brief description with dates: _____

Have you ever **considered** suicide in the **past**? YES NO

Have you **attempted** suicide recently or in the past YES NO If so, please give a brief description with dates: _____

Have you had any thoughts of wanting to kill someone else recently or in regard to your current problem? YES NO If yes, please explain _____

LEVEL OF FUNCTIONING: List or describe any current impediments or problems in daily behavioral, psychological, social or occupational functioning, i.e. isolation from friends/family, significant difficulty getting to school or work or making self do homework or daily tasks, or problems with teachers or friends, etc.

Is there any other information regarding you or your family that you would like to share with your counselor that is not covered on this form, or use this space to complete earlier responses.

I, _____ understand that in the course of providing assessment and/or counseling services, this counselor may seek consultation when necessary. Consultation will be restricted to the counselor's professional colleagues, who are also bound by professional confidentiality laws. I also understand that no details of what I discuss will be told to my parents without my permission, unless it specifically involves being a danger to myself or others. In the case of other potentially problem behaviors, I will be encouraged to share that information with my parents myself, when it is appropriate.

Adolescent's Signature _____ Date _____

Witness _____ Date _____

Thank you!