ADOLESCENT INTAKE FORM (age 12-18)

(To be completed by the adolescent)

CLIENT INFORMATION

Client name: _____ Date: _____

Birth date: ___/___/_____ Age: _____ Gender: Female _____ Male _____

PRESENTING PROBLEM

1. Describe the problems you are having and when began
   _____
   _____
   _____
2. What contributed to this difficulty?
   _____
   _____
   _____
3. What would you like to see happen as a result of counseling?
   _____
   _____

MEDICAL HISTORY

1. List allergies, serious illnesses, surgeries, injuries, and hospitalizations:
_____
_____

2. List both prescription and over-the counter mediations presently used for physical conditions:
_____
_____

3. My over-all general health is: ____ Excellent _____Good _____Fair _____Poor

EDUCATIONAL HISTORY

1. Do you have any problems in school? Y/N If yes, please explain
_____

2. Have you ever repeated or skipped a grade? Y/N _____Which one? _____

3, Have you ever been expelled or been suspended? Y/N ,_____ Please explain
_____
_____

3. How has your attendance been? ____ Excellent _____Good _____ Fair ____Poor

4. What are your grades like? _____ Have they changed a lot? Y/N _

5. Do you have learning difficulties or attend special classes? Y/N

6. Have you ever had psychological testing?

_____

TREATMENT HISTORY

1. Have you been in counseling before? Y/N _____ If so, with whom?
   _____
2. What was the primary issue?
   _____
3. Have you ever been hospitalized for emotional problems or for alcohol/drug treatment? Y/N _____
4. What medications have you taken or are you currently taken for emotional or mental problems?
   _____
   _____
5. Is there a history of mental illness in your family? If so, please explain
   _____
   _____

6. SOCIAL HISTORY
   1. What activities do you enjoy and feel you are successful when you try?
      _____
   2. Who are some of the influential and supportive people, activities or beliefs (e.g. religion) in your life? (Please describe)
   3. What are your major weaknesses?
      _____
      _____
   4. From whom do you get emotional support? _____
   5. Do you have friends? Y/N _____ How do you get along with those friends? _____
   6. Has there been a change in your circle of friends lately? Y/N _____
   7. What have been the losses, changes, crisis, and transitions in your life?
      _____
      _____
   8. Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influences your life? Please explain: _____
      _____

FAMILY HISTORY

ABOUT YOUR HOUSEHOLD

Name	Age	Relationship to you	How do you get along?

Important people in your life (immediate family/relatives/significant others)

Name	Age	Relationship to you	How do you get along?

1. Your experiences while growing up can affect your life. What experiences and events (discipline, favoritism, trauma, affection, lack of attention, etc.) have been important in your life?

_____
_____
_____

PEER RELATIONS

1. How do you consider yourself socially: outgoing _____ shy _____ depends on the situation _____
2. Are you happy with the amount of friends you have? Y/N _____
3. Have you ever been bullied? Y/N _____
4. Are your parents happy with your friends? _____
5. Are you involved in any organized social activities (e.g. sports, scouts, music)?

PERSONAL CONCERNS (PLEASE CHECK ALL THAT APPLY)

Symptom	None	Mild	Mod	Severe		Symptom	None	Mild	Mod	Severe
SADNESS						APPETITE CHANGES				
CRYING						SOCIAL ISOLATION				
SLEEP DISTURBANCES						PARANOID THOUGHTS				
PROBLEMS AT HOME						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
BINGING/PURGING						LOW ENERGY				
LONELINESS						EXCESSIVE WORRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRATABILITY						ANGER ISSUES				
NAUSSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTILATIONS						RACING THOUGHTS				
CUTTING						RESTLESSNESS				
IMPULSIVITY						DRUG USE				
NIGHTMARES						ALCOHOL USE				
HELPLESSNESS						EASILY DISTRACTED				
ELEVATED MOOD						TRAUMA FLASHBACKS				
MOOD SWINGS						OBSESSIVE THOUGHTS				
DISORGANIZED						PANIC ATTACKS				
ANOREXIA						FEELING ANXIOUS				
GRIEF						FEELING PANICKY				
HEADACHES						PAST SUICIDE ATTEMPTS				
WEIGHT CHANGES (UNPLANNED CHANGES)						OTHER				

* We would like you to know we have worked with a lot of adolescents and that we respect your privacy and we hope to create an atmosphere where you feel comfortable sharing.

FAMILY CONCERNS (PLEASE CHECK ALL THAT APPLY)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of family member		Birth of sibling
	Abuse/neglect		Birth of a child
	Job change or job dissatisfaction		Inadequate health insurance
	Inadequate housing/feeling unsafe		Other