Adolescent Intake Form

Please provide the following information and the questions below.
Please note: information you provide here is protected as confidential information.

Information Supplied By: _____

Relationship: _____

PERSONAL HISTORY

Child's name: _____ Age: _____ Gender: M ☐ F ☐

Race: _____ Grade: _____ Date of Birth: _____

Home address: _____

City: _____ State: _____ Zip: _____

Religious Affiliation (if any):_____

Referred by (if any): _____

COUNSELING HISTORY

Has the child been involved in previous counseling? Yes ☐ No ☐

If Yes, for how long: _____

Please describe reason for counseling:

_____

_____

_____

Is child currently seeing a psychiatrist? Yes ☐ No ☐

If Yes, name of psychiatrist_____

Has your child been hospitalized in the past for a psychiatric condition? Yes ☐ No ☐

If Yes, describe: _____

_____

_____

Why is the child coming to counseling? _____

_____

_____

How long has this problem persisted? _____

Under what circumstances do the problems usually get worse? _____

_____

_____

_____

Under what conditions are the problems improved? _____

_____

_____

_____

MEDICAL HISTORY:

Pediatrician's Name: _____

Address/Phone: _____

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

List any current medications: _____

_____

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Does your child have any trouble falling asleep at night? Yes ☐ No ☐

If Yes, how long has this been a problem? _____

Describe the child's appetite (during the past week):

Poor appetite ☐ Average appetite ☐ Large Appetite ☐

FAMILY HISTORY:

Mother's age_____ Father's age_____

Are parents still married? _____ If they divorced, widowed or deceased, how old

Was child when they separated, divorced and or died? _____

_____

_____

Number of sisters? _____ Their ages? _____

Number of brothers? _____ Their ages? _____

Is the child adopted or raised with parents other than biological parents? Yes ☐ No ☐

Briefly describe relationship with bothers and/or sisters: _____

_____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Describe any problems your child is having: _____

_____

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List the names and ages of those living in your household: _____

_____

History of abuse, neglect and/or trauma: _____

_____

_____

Any family history of mental illness: Yes☐ No ☐

If yes, please describe: _____

Is there any history of alcohol or drug abuse? Yes ☐ No ☐

If yes, describe_____

Briefly describe the style of parenting used in the household: _____

_____

_____

DEVELOPMENTAL AND EDUCATIONAL HISTORY:

Briefly describe any problems in the child's mother pregnancy and/or childbirth:_____

_____

_____

Any developmental concerns: _____

_____

List child's main difficulties in school: _____

_____

_____

List child's main difficulties at home: _____

_____

_____

Current School: _____

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Special Education Yes ☐ No ☐

Gifted: Yes ☐ No ☐

Has child ever been retained? Yes ☐ No ☐

Has child been suspended/expelled? Yes ☐ No ☐

If Yes, why:_____

How does child get along with peers? _____

_____

_____

Does child use or have a problem with drugs or alcohol? Yes ☐ No ☐

If Yes, describe: _____

_____

PLEASE CHECK ALL THAT APPLY & **CIRCLE** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST	DIFFICULTY WITH:	NOW	PAST
Loses temper easily	☐	☐	Doesn't finish homework	☐	☐	Fidgety	☐	☐
Argues with adults	☐	☐	Difficulty organizing tasks	☐	☐	Forgetful	☐	☐
Refuses adults requests	☐	☐	Loses things	☐	☐	Hyperactive	☐	☐
Blames others for mistakes	☐	☐	Easily distracted	☐	☐	Interrupts others	☐	☐
Easily annoyed	☐	☐	Suicide attemtps/threats	☐	☐	Poor grades in school	☐	☐
Angry/Resentful	☐	☐	Suspended from school	☐	☐	Depression	☐	☐
Spiteful/vindictive	☐	☐	Shy/withdrawn	☐	☐	Fatigued	☐	☐

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Defiant	☐	☐	Anxious/nervous	☐	☐	Excessive worrying	☐	☐
Bullies/teases others	☐	☐	Sleep disturbance	☐	☐	Panic attacks	☐	☐
Initiates fights	☐	☐	Mood shifts	☐	☐	Uses a weapon	☐	☐
Truant in school	☐	☐	Inattentive to details	☐	☐	Doesn't finish chores	☐	☐
Physically cruel to people	☐	☐	Destructive	☐	☐	Stealing	☐	☐
Physically cruel to animals	☐	☐	Forces sexual activity	☐	☐	Intentional arson	☐	☐

Has your child had legal problems (currently or in the past)? Yes ☐ No ☐

If Yes, describe:_____

_____

List the child's behaviors that you would like to see change. _____

_____

What are your goals for your child's therapy? _____

_____

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