



ADOLESCENT INTAKE FORM

In order to best serve you and your family, it is helpful for me to have some background information. Your cooperation in completing this questionnaire will enable me to do a better job and will make our time together more productive. Please complete this form collaboratively (adult/caregiver and teen). Please use two different colored pens and indicate who used which color. Color of caregiver's pen: _____ Color of teen's pen: _____

Adolescent's Full Legal Name: _____ Today's Date: _____

Teen's Date of Birth: _____ Teen's Age: _____ Gender of teen: Male Female

Name of person completing this form: _____

Biological parent Stepparent Adoptive parent Grandparent/relative Other _____

Name(s) of legal custodial parent(s): _____

Family's Home Address: _____

Home Phone: _____ May I leave a message? Yes No

Cell Phone 1: _____ May I leave a message? Yes No

Cell Phone 2: _____ May I leave a message? Yes No

Please place an asterisk (*) by your preferred phone. Email Address: _____

Referred By: _____ May I thank them for the referral? Yes No

Is anyone in your immediate family currently receiving psychiatric services, professional counseling or therapy elsewhere?

Yes No In the past? Yes No Please explain: _____

Teen only: Please circle the number that describes why you are coming to therapy. Please indicate if you are here by choice (10) or because your caregiver/parent organized therapy for you (1) or somewhere in between.

1 2 3 4 5 6 7 8 9 10

"I don't want to be here at all. My parent forced me to come."

"Therapy might be helpful for me but I'm not sure. I might have some things I'm interested in working on."

"It was my idea to come to therapy."

Please describe your reason for seeking counseling services. Please note when the challenges began and what you hope to accomplish in our work together. (It's okay if these are different for caregiver and teen.)

Teen: _____

Caregiver/parent: _____

Family Members:

Please list names, ages, and relations of each person living in the household:

Name	Age	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list other members of immediate family (parents and siblings who do not live with the child):

Name	Age	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

Do any family members struggle with the following challenges? (Family is defined as brother, sister, parent, grandparent, aunt, or uncle.)

Learning challenges/disability:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Depression/Bipolar Disorder:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Alcoholism/drug addiction:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Anxiety/panic Attacks:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Trauma (sexual assault, combat, abuse, etc.):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Suicide attempts:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Eating disorders (Anorexia/Bulimia):	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Hyperactivity/ADHD:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____
Other behavior or emotional problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Family Member: _____

Significant Medical Events:

Have you (teen) experienced any major illnesses, operations, injuries, or allergies? Yes No

Event: _____ Age of Teen: _____

Family's response to this event: _____

Event: _____ Age of Teen: _____

Family's response to this event: _____

Medication:

Please describe any medications that address mental health related issues:

Name, dosage and goal of medication	Age of child	Effective?	Currently taking it?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Early Development:

Were there any complications during pregnancy? Yes No If yes, please explain: _____

Did mother take medication during pregnancy? Yes No If yes, please explain: _____

Did mother use drugs/alcohol during pregnancy? Yes No If yes, please explain: _____

Were there complications during birth? Yes No If yes, please explain: _____

Was the pregnancy full term? Yes No If yes, please explain: _____

In teen's first year of life, did he/she experience:

Colic? Yes No Feeding problems? Yes No Sleeping problems? Yes No

Did he/she meet developmental milestones (walking, talking, crawling) on time? Yes No

Please describe the teen as a baby:

Social and School Functioning:

Please describe how you (the teen) interact with peers and other teens (please include siblings):

What do you (teen) like to do with friends?

How much time is spent watching television/playing videogames/using the computer daily?

Are you (the teen) having any challenges at school (suspension, failing, truancy, trouble with teachers, etc.)?

Please describe your (teen's) academic performance (grades):

Have you (teen) ever been diagnosed with a learning disability/problem? Yes No If yes, please explain:

Do you (teen) use special education services (have an IEP)? Yes No If yes, please explain:

Symptoms:

Please make a check mark to indicate that you (teen) are experiencing this symptom then indicate on a scale from 1-5 how severe the symptom is. 1 notes that you experience this symptom very infrequently and that the symptom is minimally disruptive. 5 notes that you experience this symptom frequently and it is extremely disruptive.

Sadness/Mood

Is this a problem? If so, please check.	rarely		sometimes		always
_____ Appearing mopey and sad	1	2	3	4	5
_____ Irritability	1	2	3	4	5
_____ Withdrawing from others	1	2	3	4	5
_____ Decreased enjoyment in activities	1	2	3	4	5
_____ Change in sleep pattern	1	2	3	4	5
_____ Low self-esteem	1	2	3	4	5
_____ Weight loss/gain	1	2	3	4	5
_____ Excessive tantrums/rages	1	2	3	4	5
_____ Emotions that change quickly	1	2	3	4	5

Anxiety

Is this a problem? If so, please check.	rarely		sometimes		always
_____ Worried or anxious	1	2	3	4	5
_____ Obsessive or compulsive	1	2	3	4	5
_____ Stomachache/headache	1	2	3	4	5
_____ Restlessness	1	2	3	4	5
_____ Nightmares	1	2	3	4	5
_____ Witnessed traumatic event	1	2	3	4	5
_____ Trouble concentrating	1	2	3	4	5
_____ Trouble falling asleep	1	2	3	4	5

Defiance/Misc. Behavior

Is this a problem? If so, please check.	rarely		sometimes		always
_____ Defies adult requests	1	2	3	4	5
_____ Aggressive towards people/animals	1	2	3	4	5
_____ Stealing	1	2	3	4	5
_____ Lying	1	2	3	4	5
_____ Destroys property	1	2	3	4	5
_____ Sexually acting out	1	2	3	4	5
_____ Fire setting	1	2	3	4	5

_____ Argues with adults	1	2	3	4	5
_____ Running away from home	1	2	3	4	5
_____ Threatens self harm/harm to others	1	2	3	4	5
_____ Cutting	1	2	3	4	5

ADHD

Is this a problem? If so, please check.	rarely		sometimes		always
_____ Difficulty paying attention	1	2	3	4	5
_____ Poor concentration	1	2	3	4	5
_____ Has difficulty organizing homework	1	2	3	4	5
_____ Poor impulse control	1	2	3	4	5
_____ Fidgets	1	2	3	4	5

Are there any additional behaviors/symptoms you have concerns about? If so, please explain:

Strengths and Spirituality:

Please tell me about the things you (teen) are good at/proud of:

(Caregiver/parent) Describe your teen's best qualities:

What gives you (teen) strength during challenging times?

Do you or your family have a religious affiliation, spiritual belief system or way of life that would be helpful for me to know about?

What are your (teen's) hobbies, extracurricular activities or interests?

Is there anything else that is important for me to better understand your current challenges and work with your family?

Thank you for your assistance in completing this assessment.