Welcome to *Mind Your Breath Counseling LLC*. Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

**ADOLESCENT INTAKE FORM (ages 12-17)**

Adolescent please fill out pages 1-5, parent/guardian please fill out pages 6-13; All pages must be initialed by both parent and child.

CLIENT INFORMATION

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_Male \_\_\_ Female

Phone (Cell): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Messages okay?\_\_\_ Text reminder okay?\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_

Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your parents have access to your electronic communication? (Y/N) \_\_\_\_\_\_\_\_\_\_Do they have any issues with your use of phone, text, electronic communication? (Y/N) \_\_\_\_\_\_\_\_\_\_

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life?

(Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to see happen as a result of counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor?  Yes  No

If yes, what did you find most helpful in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, what did you find least helpful in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHEMICAL USE AND HISTORY

Do you currently use alcohol? \_\_\_\_\_Yes, \_\_\_\_\_No

If yes, how often do you drink? \_\_\_\_\_Daily, \_\_\_\_\_\_Weekly, \_\_\_\_\_Occasionally, \_\_\_\_\_Rarely

If yes, how much do you drink? \_\_\_\_\_\_\_\_\_\_\_\_(#) per time.

Do you currently use Tobacco? \_\_\_\_\_\_Yes, \_\_\_\_\_No

If yes, how much do you smoke/chew? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use any other drugs? \_\_\_\_\_\_\_Yes, \_\_\_\_\_\_No

If yes, what drugs do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, how often do you use? \_\_\_\_\_Daily, \_\_\_\_\_\_Weekly, \_\_\_\_\_\_Occasionally, \_\_\_\_\_Rarely

Have you received any previous treatment for chemical use? Y/N \_\_\_\_\_\_\_\_\_

If so, where did you go?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_Inpatient \_\_\_\_\_\_\_\_\_Outpatient

Adolescents (please answer the following with Y/N)

1. Have you ever used more than 1 chemical at the same time to get high? \_\_\_\_\_\_\_\_\_

2. Do you avoid family activities so you can use? \_\_\_\_\_\_\_

3. Do you have a group of friends who also use? \_\_\_\_\_\_\_

4. Do you use to improve your emotions such as when you feel sad or depressed?? \_\_\_\_\_\_\_

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect

upon you in the past.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY HISTORY

1. Are your parents married or divorced? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you think their relationship is good? (Y/N/Unsure)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. If your parents are divorced, whom do you primarily live with? \_\_\_\_\_\_\_\_\_\_\_\_\_

4. How often do you see each parent? Mom\_\_\_\_\_\_\_\_\_% Dad \_\_\_\_\_\_\_\_\_\_\_%.

5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or

outside your home? Please describe as much as you feel comfortable.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY CONCERNS (Please circle any family concerns that your family is currently experiencing)

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

Other concerns not listed above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? (Y/N)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Are involved in any organized social activities ( e.g. sports, scouts, music)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SCHOOL HISTORY

1. Do you like school? (Y/N)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Do you attend regularly? (Y/N)\_\_\_\_\_\_\_\_\_\_\_\_\_

3. What are your current grades? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Do you feel you are doing the best you can at School? (Y/N) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INDIVIDUAL CONCERNS (Please check next to any concerns you may have below)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | SADNESS |  | APPETITE CHANGES |
|  | CRYING |  | SOCIAL ISOLATION |
|  | SLEEP DISTRUBANCES  |  | PARANOID THOUGHTS |
|  | PROBLEMS AT HOME  |  | POOR CONCENTRATION |
|  | HYPERACTIVITY  |  | INDECISIVENESS |
|  | BINGING/PURGING  |  | LOW ENERGY |
|  | LONELINESS  |  | EXCESSIVE WORRY |
|  | UNRESOLVED GUILT  |  | LOW SELF WORTH |
|  | IRRITABILITY  |  | ANGER ISSUES |
|  | NAUSEA/INDIGESTION  |  | SPIRITUAL CONCERNS |
|  | SOCIAL ANXIETY  |  | HALLUCINATIONS |
|  | SELF MUTILATION  |  | RACING THOUGHTS |
|  | CUTTING  |  | RESTLESSNESS |
|  | IMPULSIVITY  |  | DRUG USE |
|  | NIGHTMARES  |  | ALCOHOL USE |
|  | HOPELESSNESS  |  | EASILY DISTRACTED |
|  | ELEVATED MOOD  |  | TRAUMA FLASHBACKS |
|  | MOOD SWINGS  |  | OBSESSIVE THOUGHTS |
|  | DISORGANIZED  |  | PANIC ATTACKS |
|  | ANOREXIA |  | FEELING ANXIOUS |
|  | GRIEF  |  | FEELING PANICKY |
|  | PHOBIAS  |  | SUICIDAL THOUGHTS |
|  | HEADACHES  |  | PAST SUICIDE ATTEMPTS |
|  | WEIGHT CHANGES |  | OTHER |

If you have checked next to any concerns, please specify if you are: 1. Very Concerned; 2. Somewhat Concerned; 3. Not Very Concerned. Please write this information next to the concern.

\*We would like you to know that 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.

**For Parents**

Welcome to Mind Your Breath Counseling. Please note that the information is important for your child’s care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Male \_\_\_ Female

Race/Ethnic Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Religious Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT HOUSEHOLD AND FAMILY INFORMATION (please include all household members)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name  | Relationship (parent, sibling, etc) | Age | Sex | Type(bio, step,etc) | Livingwith you?Y/N |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

 (If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to see happen as a result of counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is most concerning right now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILD’S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes \_\_\_ No \_\_\_ If yes, describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Did your child have health problems at birth? Yes \_\_\_\_\_ No \_\_\_\_\_\_

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes \_\_\_ No \_\_\_ Not sure\_\_\_\_\_

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Did your child have any unusual behaviors or problems prior to age 3? Yes \_\_\_ No \_\_\_

Not sure\_\_\_\_\_ If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Has your child experienced emotional, physical, or sexual abuse?

Yes \_\_\_\_ No \_\_\_\_ Not sure \_\_\_\_\_ If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNSELING HISTORY

Have your son or daughter previously seen a counselor?\_\_\_ Yes \_\_\_\_No

If Yes, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate Dates of Counseling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For what reason did your son or daughter go to counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your son or daughter have a previous mental health diagnosis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you find most helpful in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What did you find least helpful in therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your son or daughter used psychiatric services? Yes\_\_\_\_ No\_\_\_\_

If yes, who did they see? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, was it helpful? N/A\_\_\_\_ Yes\_\_\_\_ No\_\_\_\_\_\_

Has your son or daughter taken medication for a mental health concern? Yes\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Name of medication Dates taken Was it helpful? (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N \_\_\_\_\_\_\_

If so, please describe. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) \_\_\_\_\_\_\_\_\_

If yes, please explain your concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook,

Snapchat, Twitter, texting etc? (Y/N) \_\_\_\_\_\_\_\_\_

If yes, please explain your concern: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon

you or your son or daughter in the past. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please

describe as much as you feel comfortable. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARENT’S MARITAL STATUS ( this question refers to the biological parents relationship)

\_\_\_Single \_\_\_Married (legally) \_\_\_Divorced Cohabitating \_\_Divorce in process \_\_\_Separated \_\_\_Widowed \_\_\_Other

Length of marriage/relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If divorced, how old was your child at time of divorce? \_\_\_\_\_

If divorced, How much time does your child spend with each parent? Mother\_\_\_\_\_%, Father \_\_\_\_\_%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Ethnic Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total years of education completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_ Combat experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Status \_\_\_\_\_Single, \_\_\_\_Married, \_\_\_\_Divorced, \_\_\_\_Separated, \_\_\_\_\_Widowed, \_\_\_\_\_Other

\*Please answer if you are no longer with your child’s bio-mother OR check here if you are still with bio-mother\_\_\_\_\_\_\_\_\_\_\_

Assessment of current relationship if applicable: Poor\_\_\_\_\_ Fair\_\_\_\_\_\_\_ Good\_\_\_\_\_\_\_\_\_

Biological Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date:\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_

Ethnic Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total years of education completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_ Combat experience? Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Status \_\_\_\_\_Single, \_\_\_\_Married, \_\_\_\_Divorced, \_\_\_\_Separated, \_\_\_\_\_Widowed, \_\_\_\_\_Other

\*Please answer if you are no longer with your child’s bio-father OR check here if you are still with bio-father\_\_\_\_\_\_\_\_\_\_\_

Assessment of current relationship if applicable: Poor\_\_\_\_\_ Fair\_\_\_\_\_\_\_ Good\_\_\_\_\_\_\_\_\_

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

|  |  |  |  |
| --- | --- | --- | --- |
|  | 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 |  | Financial problems |
|  | Divorce/separation |  | Death of a family member |
|  | Issues regarding remarriage |  | Abuse/neglect |
|  | Birth of a sibling |  | Inadequate housing/feeling unsafe |
|  | Birth of a child |  | Job change or job dissatisfaction |
|  | Inadequate health insurance |  | Other |

YOUR ADOLESCENT’S STRENGTHS

What activities do you feel your son or daughter is successful when they try? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What personal qualities would you say your son or daughter has? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter’s

life? (Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INDIVIDUAL CONCERNS ABOUT YOUR CHILD (Please check next to any concerns you may have below)

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  | SADNESS |  | APPETITE CHANGES |
|  | CRYING |  | SOCIAL ISOLATION |
|  | SLEEP DISTRUBANCES  |  | PARANOID THOUGHTS |
|  | PROBLEMS AT HOME  |  | POOR CONCENTRATION |
|  | HYPERACTIVITY  |  | INDECISIVENESS |
|  | BINGING/PURGING  |  | LOW ENERGY |
|  | LONELINESS  |  | EXCESSIVE WORRY |
|  | UNRESOLVED GUILT  |  | LOW SELF WORTH |
|  | IRRITABILITY  |  | ANGER ISSUES |
|  | NAUSEA/INDIGESTION  |  | SPIRITUAL CONCERNS |
|  | SOCIAL ANXIETY  |  | HALLUCINATIONS |
|  | SELF MUTILATION  |  | RACING THOUGHTS |
|  | CUTTING  |  | RESTLESSNESS |
|  | IMPULSIVITY  |  | DRUG USE |
|  | NIGHTMARES  |  | ALCOHOL USE |
|  | HOPELESSNESS  |  | EASILY DISTRACTED |
|  | ELEVATED MOOD  |  | TRAUMA FLASHBACKS |
|  | MOOD SWINGS  |  | OBSESSIVE THOUGHTS |
|  | DISORGANIZED  |  | PANIC ATTACKS |
|  | ANOREXIA |  | FEELING ANXIOUS |
|  | GRIEF  |  | FEELING PANICKY |
|  | PHOBIAS  |  | SUICIDAL THOUGHTS |
|  | HEADACHES  |  | PAST SUICIDE ATTEMPTS |
|  | WEIGHT CHANGES |  | OTHER |

If you have checked next to any concerns, please specify if you are: 1. Very Concerned; 2. Somewhat Concerned; 3. Not Very Concerned. Please write this information next to the concern.

Is there anything else you would like to share: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Special Confidentiality Notice for Parents**

Your child has the right to private, confidential communication therapist team providing his or her care. This

means that some of the issues that they discuss will stay between them, and that we will not disclose that

information to anyone, including you, unless we have been given permission by your child to do so. We need

your child to be open and honest with us in order to understand and treat the full range of issues your child is

dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also

recognize it is very important for you to know what your child is going through in order to do your job as a

parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and

support your child so that they feel safe enough to share those issues with you.

According to Florida law, and the federal patient privacy law known as HIPAA, your child will need to

give his/her consent for us to disclose:

• All Mental Health records for children age 16 or older.

• All information concerning pregnancy, sexual activity, STD’s, and drug/alcohol use or abuse,

regardless of the child’s age.

• Any information that your child’s provider believes, if released, could cause harm to your child

or to someone else, or that would significantly harm the treatment relationship with your child.

• You should know that this confidentiality has limits. If there is any threat to your child’s life, we have

the duty to inform you and help to create a plan for safety.

• In addition, there are situations that we are mandated to report and cannot keep confidential. Those

situations include: threats against another person, physical or sexual abuse, neglect, and pregnant

women who report using drugs.

• Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child

has emotional/behavioral concerns. We know how badly you might want to know everything your child may

have not shared with you. We want to be your partner in supporting your child’s physical and mental

wellbeing, and even when we can’t discuss certain details about your child with you, we will always be

there for you: guiding you and giving your child the best advice possible to protect him/her and

encourage healthy decisions, including being open and honest with you.