ADOLESCENT INTAKE (Parent Section) Confidential Please Print Clearly

Name of Adolescent_____Birthdate_____Age_____
Gender: M / F
Address_____City_____State_____

Zip_____ School _____Grade_____

List the persons with whom your teen is now living, their age and their relationship to him/her_____

Biological/Adoptive Father (circle one) _____Birthdate_____
Address_____City_____State_____Zip_____
Phone_____
Occupation_____Employer_____EducationLevel_____

Biological/Adoptive Mother (circle one) _____Birthdate_____
Address_____City_____State_____Zip_____
Phone_____
Occupation_____Employer_____EducationLevel_____

Step-Father_____Birthdate_____
Address_____City_____State_____Zip_____
Phone_____
Occupation_____Employer_____EducationLevel_____

Step-Mother_____Birthday_____
Address_____City_____State_____Zip_____
Phone_____
Occupation_____Employer_____EducationLevel_____

Adopted? ____Yes ____No

At what age? _____ Medical/social history of birth parents ____Known____ Unknown

Who has legal custody? _____

*If divorced, please provide a copy of your custody agreement. Marital status of the biological/adoptive parents of the child (check all that apply):
Married __ Living Together__ Separated__ Divorced__ Not Married__

One Parent Deceased__ Father Remarried__ Mother Remarried__

Please list all of your children, living and deceased, in the order of their birth

Name_____ Age_____ Birthdate_____ Gender_____

Name_____ Age_____ Birthdate_____ Gender _____

Name_____ Age_____ Birthdate_____ Gender _____

Name_____ Age_____ Birthdate_____ Gender _____

Name_____ Age_____ Birthdate_____ Gender _____

REFERRAL

How did you find out about my practice? _____

How did you find my website? _____ Name of referral source _____
Phone Number of referral source _____

PROBLEM INFORMATION

Briefly describe your primary concern about your adolescent:

_____
_____
_____

Briefly describe the history and development of your concern from onset to present:

_____
_____
_____

Why are you coming for counseling now instead of a few months ago or a few months from now?

_____
_____
_____

What are your goals for your son or daughter in counseling?

_____
_____
_____

What specific anxieties do you have about counseling?

_____
_____
_____

Has your adolescent been to counseling before? _____If so, when? _____With whom?_____ If so, briefly describe their experience

_____
_____

Have your adolescent's report cards or school conferences indicated any special or specific difficulties?

_____
_____

What grades has your son/daughter repeated? _____ What special needs and/or learning disabilities does your adolescent have?

_____
_____

DEVELOPMENTAL HISTORY

Mother's health during pregnancy if known _____ Medication/drugs/alcohol taken (specify)

_____

Length of labor_____ Forceps used? ____Yes ____No
Birth weight_____ Problems/complications before or after delivery?

_____

Number of lost pregnancies: _____ At what age did your child accomplish the following?
Sat alone _____Walked alone _____Toilet trained_____
Crawled _____Said words _____Rode bicycle (2-wheeler)_____
Stood alone _____Used sentences _____Was able to read_____

Who and at what ages, other than the mother, was involved in caring for the child from infancy to five years of age?

_____

PHYSICAL HEALTH
Please list any medical problems, serious illnesses and/or hospitalizations your adolescent has had and the approximate dates

_____

_____

_____

Date of most recent physical examination _____Name of primary care physician _____

Please list any medications your son or daughter is currently taking: (medication, reason, prescribed dose, and frequency)

_____

_____

_____

Does your son or daughter have a history of or current problem with any of the following areas?
Eating Problems _____Bed-wetting _____Masturbation _____Head Injuries_____
Sleep Difficulties _____Wetting Pants_____Runaway_____Headaches_____
Speech Difficulties _____Soiling Pants _____Truancy_____ Temper Tantrums_____
High Fevers_____ Constipation _____Distractibility _____Social Withdrawal_____

Has your child ever been neglected and/or abused? If so, please describe:

_____

_____

_____

Do any family members have any special medical problems? _____No _____Yes If yes please explain:_____

_____

_____

_____

Please identify any family history of:
Alcoholism_____ Developmental Delays_____ Learning Disabilities_____ Drug Abuse_____ Emotional Problems_____
Over-activity_____ Suicide_____ Marital Problems_____ Bi-polar Disorder_____ Suicide Attempts_____
Depression_____ Physical or Sexual Abuse_____ Occult/Witchcraft_____ Schizophrenias_____ Imprisonment_____

Check any of the following which definitely describe your son or daughter

□ Selfish □ Spoiled □ Moody □ Vain □ Clean □ Kind □ Sweet □ Unfocused □ Sexual Concerns □ Sassy □ Resents Authority □ Quarrelsome □ Doesn't Care □ Unmotivated □ Depressed □ Defiant □ Dramatic □ Flirtatious □ Compliant □ Teachable □ Vengeful □ Reclusive □ Ill-tempered □ Considerate □ Obedient □ Industrious □ Easily Led □ Forgiving □ Emotional □ Inadequate □ Adaptable □ Silliness □ Unruly □ Untruthful □ Disobedient □ Fearful □ Resentful □ Stubborn □ Violent □ Sensitive □ Awkward □ Untidy □ Polite □ Thoughtful □ Opinionated

Describe what activities you typically engage in with your teenager?

_____

_____

_____

What does your child enjoy doing for fun?

_____

_____

_____

What extra-curricular activities is your child involved in?

_____

_____

_____

How many times and for what reasons has your family moved during your adolescent's life?

_____

_____

_____

As parent and/or legal guardian, of the daughter/son described above, do you give permission for him/her to engage in counseling and/or assessment with Desiree Bramlett, MS; LMFT?_____ Yes _____ No
Is the information you have provided on this form true and accurate? _____ Yes _____ No

Signature:_____ Date:_____

ADOLESCENT INTAKE (PARENT: PLEASE HAVE YOUR DAUGHTER/ SON COMPLETE THIS SECTION.) Confidential

Please Print Clearly

Name

_____Birthdate_____Age_____Gender: M / F

School_____Grade_____

Briefly describe how I can help you:

_____

_____

_____

_____

Current Stressors (describe how the following areas are stressful):

Parents

_____

Brothers/ Sisters

_____

School

_____

Work

_____

Friends/ Social

_____

Spiritual

_____

Sexual

_____

Other

_____

Rate how strongly you want to change your present problem on the scale below: (do not want to change) 1 2 3 4 5 6 7 8 9 10 (desperately desire to change)

Identify any specific concerns or fears you have about counseling:

_____

_____

_____

_____

What are your specific goals for counseling?

_____

_____

Previous counseling? _____ When? _____ By Whom? _____

How helpful was previous counseling?

_____

_____

Current symptoms (Please check all that apply to you):

□ Headaches □ Dizziness □ Fainting Spells □ Nervousness □ Stomach Trouble □ No Appetite □ Bowel Disturbances □ Recent Weight Gain □ Recent Weight Loss □ Fatigue □ Sleep Disturbances □ Racing Thoughts □ Nightmares □ Alcoholism □ Drugs □ Take Sedatives □ Don't like weekends & vacations □ Feel Lonely □ Feel Depressed □ Unable to have a good time □ Suicidal Thoughts/ Feelings □ Shy with people □ Can't make Friends □ Unable to Relax □ Over-ambitious □ Can't make decisions □ Persistent Fears □ Financial Concerns □ Sexual Concerns □ Recurrent Troubling Thoughts □ Bad Home Conditions □ Inferiority Feelings □ Other

FAMILY BACKGROUND

Father's Name_____ If deceased, date and cause_____

Age_____ Occupation_____ Education Level_____

Health_____ Describe his personality, attitude and relationship to you, past and present_____

_____

_____

Mother's Name_____ If deceased, date and cause_____

Age_____ Occupation_____ Education Level_____

Health_____ Describe her personality, attitude and relationship to you, past and present_____

_____

_____

Parent's marital status_____ Briefly describe your parent's marriage _____

_____

_____

_____

How do they handle conflict in their relationship?

_____

_____

If divorced, when did it occur and what was your reaction to it?

_____

_____

_____

If one or both parents remarried, give date (s) and your reaction

_____

_____

_____

Step- Mother's Name

_____Age_____

Occupation_____ Education Level_____

Health_____ Describe her personality, attitude and relationship to you, past and present_____

_____

_____

Step- Father's Name

_____ Age_____

Occupation_____ Education Level_____

Health_____ Describe his personality, attitude and relationship to you, past and present_____

_____

_____

If you were not raised by your parents, who raised you?

_____ Between what years? _____

Who took care of you as an infant?

_____

How were you disciplined as a child and by whom?

_____

_____

_____

Please list all your brothers and sisters, in the order of their birth:

Name_____ Age_____ Birthdate_____ Gender_____

Name_____ Age_____ Birthdate_____ Gender _____

Name_____ Age_____ Birthdate_____ Gender _____

Name_____ Age_____ Birthdate_____ Gender _____

Name_____ Age_____ Birthdate_____ Gender _____

Give your impression of your home atmosphere, including how compatible you and everyone else are.

_____

_____

_____

As you were growing up, how has love been expressed in your home?

_____

_____

_____

How has anger been expressed?

_____

_____

_____

What are your parents' attitudes about sex and has there been any discussion of or instruction about sexuality in the home?

_____

_____

_____

Have you or your siblings ever been physically and/or sexually abused, assaulted, or neglected?

_____

If so, in what ways?

_____

How many dating relationships have you been in?

_____

PHYSICAL HEALTH

Present heath status (circle one): Excellent/ Good / Fair / Poor

What serious illnesses have you had and when?

_____

_ Hospitalizations (reason/diagnosis/ dates)

_____

Medications currently taken and their purpose (include non-prescription medications, e.g. sleeping pills, diet pills, etc.)

_____

_____

_____

Please list amount and frequency of alcohol use

_____

Please list any drugs you have used, including amount and frequency

_____

_____

_____

If you do so, at what age did you start drinking alcohol? _____If you do so, at what age did you start using drugs? _____

When and where was your last vacation?

_____

What do you enjoy doing for fun?

_____

_____

RELIGIOUS ORIENTATION

Describe the religious training you received while growing up and how God is viewed by your family_____

_____

_____

How would you describe your current spiritual life?

_____

_____

What is your current activity/ involvement in church/ faith community?

_____

_____

Check any of the following character traits which definitely describe you:

□ Selfish □ Spoiled □ Moody □ Vain □ Clean □ Kind □ Sweet □ Unfocused □ Sexual Concerns □ Sassy □ Resents Authority □ Quarrelsome □ Doesn't Care □ Unmotivated □ Depressed □ Defiant □ Dramatic □ Flirtatious □ Compliant □ Teachable □ Vengeful □ Reclusive □ Ill-tempered □ Considerate □ Obedient □ Industrious □ Easily Led □ Forgiving □ Emotional □ Inadequate □ Adaptable □ Silliness □ Unruly □ Untruthful □ Disobedient □ Fearful □ Resentful □ Stubborn □ Violent □ Sensitive □ Awkward □ Untidy □ Polite □ Thoughtful □ Opinionated

Do you consent to participate in counseling/ assessment with Desiree Bramlett, MS; LMFT? _____Yes _____No

Is the information you have provided on this form true and accurate? _____Yes_____ No

Signature_____Date_____