Adolescent Intake Form

(Ages 14-18)

Name			
Date of Birth		**Grade**	
Mailing Address			
Phone Number **Cell Phone?: Y / N**			
E-mail Address			

What are the main concerns regarding your adolescent's behaviors?

What do you hope this evaluation will help to improve?

What are your adolescent's strengths?

Please check all that apply to your adolescent.

My adolescent is demonstrating difficulties with relationships in the following ways:

- ☐ Getting along with family
- ☐ Getting along with peers
- ☐ Engaging in conversations
- ☐ Understanding jokes
- ☐ Making eye contact
- ☐ Easily embarrassed
- ☐ Establishing and maintaining friendships
- ☐ Stubbornness
- ☐ Distrustful, suspicious, secretive
- ☐ Lying, sneaking
- ☐ Frequent arguing
- ☐ Explosive episodes

My adolescent is demonstrating difficulties with externalizing behaviors in the following ways:

- ☐ Acting violently & losing temper
- ☐ Fire-setting
- ☐ Rule breaking
- ☐ Property Destruction
- ☐ Stealing
- ☐ Cruelty to animals
- ☐ Running away
- ☐ Risk-taking behaviors
- ☐ Alcohol abuse
- ☐ Abuse perpetrator
- ☐ Obsessions & compulsions
- ☐ Perfectionism
- ☐ Rigid & Inflexible
- ☐ Head-banging/rocking
- ☐ Skin-picking
- ☐ Hair-pulling
- ☐ Poor frustration tolerance
- ☐ Nightmares

My adolescent is demonstrating difficulties with language & learning in the following ways:

- ☐ Resistance to school
- ☐ Reading, writing, & spelling
- ☐ Comprehending math concepts
- ☐ Comprehending oral and/or written language
- ☐ Getting started on a task
- ☐ Staying on task
- ☐ Completing a task
- ☐ Following directions
- ☐ Poor impulse control
- ☐ Poor judgement
- ☐ Poor handwriting
- ☐ Conversations seem to be disorganized
- ☐ Responses to questions seem to be 'off'

My adolescent is demonstrating difficulties with physical functioning in the following ways:

- ☐ Tics/twitching
- ☐ Dizziness
- ☐ Pain/body complaints
- ☐ Sensory Issues
- ☐ Blank Spells
- ☐ Bed-wetting/Frequent urinary accidents
- ☐ Soiling
- ☐ Sleeps too much
- ☐ Sleeps too little
- ☐ Overeating
- ☐ Restrictive eating
- ☐ Nail-biting
- ☐ Poor coordination
- ☐ Clumsy with hands

Birth & Early Childhood Development History

Length of Pregnancy (in months): _____

Any illnesses or complications while pregnant? If yes, please explain: _____

_____

Please list any medications prescribed to the mother during pregnancy: _____

_____

Did the mother use any of the following while pregnant? (C*heck all that apply*):

- ☐ Caffeine
- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational Drugs
- ☐ Prescription medication/treatment other than routine prenatal care
- ☐ Other

How was baby delivered? (*Please circle one*): vaginally cesarean section

Birth weight and length: _____

Please describe any complications experienced following the birth of the child: _____

_____

When your adolescent was an infant and toddler, how would you rate the following behaviors?

	Average		Moderate		Severe	
Quiet & content	1	2	3	4	5	**Colicky and irritable**
Very easy to feed	1	2	3	4	5	**Daily feeding problems**
Slept well	1	2	3	4	5	**Frequent sleeping problems**
Usually relaxed	1	2	3	4	5	**Often restless**
Underactive	1	2	3	4	5	**Overactive**
Cuddly, easy to hold	1	2	3	4	5	**Did not enjoy cuddling**

	Average		Moderate		Severe	
Easily calmed down	1	2	3	4	5	**Tantrums or Head banging**
Cautious and careful	1	2	3	4	5	**Accident prone & Daredevil**
Coordinated	1	2	3	4	5	**Uncoordinated**
Enjoyed eye contact	1	2	3	4	5	**Avoided eye contact**
Liked people	1	2	3	4	5	**Disliked contact with people**

Family History

	Birth Mother	Birth Father
Age		
Highest Grade Completed		
Diploma or Degree		
Occupation		

Adoption History

Was the child adopted? _____

From where was the child adopted? _____

At what age was the child adopted?_____

Provide any information you may have bout the birth mother/father. _____

_____

_____

Medical History

Does your adolescent have or has s/he ever had any of the following? (*Check all that apply)*

- ☐ Meningitis
- ☐ Loss of Consciousness
- ☐ Head Injuries/Concussion
- ☐ High Fever
- ☐ Ear Infections
- ☐ Asthma
- ☑ Heart Disease
- ☐ Seizures
- ☑ Other Illness

Please describe treatment given and any complications for illnesses or injuries indicated above:

_____

Has your child ever been hospitalized? If yes, for what? _____

_____

Describe any hearing or vision problems: _____

_____

List any previous surgeries, child's age and length of hospitalization: _____

_____

Is your adolescent currently taking any medications? If yes, please list.

Medication	Dosage

Psychiatric History

Has your adolescent been hospitalized? Participated in an outpatient program? If so, please elaborate. _____

_____

Does your adolescent demonstrate the following behaviors?

	Not at all	1-2 Days/week	3-4 Days/week	Everyday
Has thoughts of self-harm				
Feels sad, empty, hopeless				
Cries easily and frequently				
Is irritable, moody, sullen, pouts				
Has lost pleasure in activities previously enjoyed				
Sleeps too much or too little				
Seems restless				
Behaviors seemed to be slowed down; seems listless				
Fatigue/loss of energy				
Feelings of worthlessness				
Excessive or inappropriate guilt				
Negative & self-critical thoughts				
Decreased ability to think or concentrate				
Socially withdrawn & isolated				
Is indecisive & easily confused				
Complains of stomachaches & headaches				
Feels nervous, anxious, restless, on edge				
Excessive worrying, irritable, impatient				
School refusal				
Trouble relaxing and sitting still & restlessness				

	Not at all	1-2 Days/week	3-4 Days/week	Everyday
Is afraid that something 'bad' is going to happen				
Engages in repetitive behaviors to manage the worry				
Easily fatigued, sleep disturbance, muscle tension				

Has your adolescent worked with a therapist? If so, please elaborate. _____

_____

_____

School History

Name of adolescent's current school: _____

Grade: _____

Has your adolescent received any of the following? Complete all that apply.

	Dates or Grades	Additional Information
504 Plan:		
IEP (Special Education):		

Have teacher's reported concerns recently? If yes, in what areas (*please circle*)?

Reading	Arithmetic	Social Adjustment
Writing	Attention Span	Following Directions
Spelling	Activity Level	
Other:		

Substance History

Do you have any history of any recreational drug use? _____

What drugs have been used/abused? _____

Teen Learning Disability Screening Questionnaire

Please rate your teen on each of the symptoms listed below using the following scale:
0=never ◆ 1= rarely ◆ 2=occasionally ◆ 3= frequently ◆ 4= very frequently ◆ N/A not applicable

Reading	**Rating**
Poor reader	
Does not like to read	
Makes mistakes when reading (e.g., skipping lines)	
Has problems remembering what was read	
Reverse letters when reads	
Switches letters in words when reading	
Eyes hurt or water when reading	
Tends to combine words when reading	
Has difficulty understanding the main idea	
Has difficulty understanding the important points	
Has trouble sounding out words	
Words tend to blur when reading	
Oral Expressive Language (*Has difficulty with…)*	**Rating**
Expressing self in words	
Getting to the point	
Answering questions people ask	
Answering questions as quickly as other students	
Asking for help when needed	
Formulating questions	
Verbally expressing thoughts	
Using a variety of vocabulary when talking	
Describing this to people	
Staying on topic when talking	
Putting events in the right order when telling stories	
Talking about things that have happened in an organized manner	
Using correct grammar when talking	
Using complete sentences when talking (speak in short, choppy manner)	
Expanding an answer or providing details when talking	
Having a conversation with someone	
Saying something another way when people do not understand what he/she said	
Getting angry or upset when people do not understand what he/she said	

Finding the right words to say in a conversation	
Providing a clear answer to a question ('off topic')	
Writing	**Rating**
Has 'messy' handwriting	
Work tends to be messy & disorganized	
Letters run into each other/no spaces between letters	
Has trouble staying within the lines	
Prefers to print rather than write in cursive	
Problems with punctuation and grammar	
Has trouble copying off the board	
Has trouble getting thoughts from brain to paper	
Can tell a story, but cannot write one	
Writes in shorty, choppy sentences	
Has trouble expanding an answer or providing details	
Has trouble putting words in the right order when writing	
Receptive Language *(difficulty with…)*	**Rating**
Understanding people and tends to give the wrong answer in conversation	
Understanding directions, following a lecture,	
Keeping up with what is being said in a conversation	
Remembering what people have said to him/her (people have to repeat what they say)	
Understanding the meaning of words	
Understanding new ideas	
Seems to be confused or 'lost' in a conversation	
Needs information 'broken down' to simplistic structures	
Social Skills	**Rating**
Has few or no friends	
Has trouble reading body language and facial expressions	
Tends to get into trouble with friends, teachers, other adults	
Feels uncomfortable around people he/she does not know well	
Is teased by others	
Friends do not call and ask to get together with him/her	
Does not get together with others outside of school	
Body Awareness/Spatial Awareness	**Rating**
Confuses/has difficulty with left from right	
Problems writing within the lines	
Difficulty maintaining balance	
Clumsy & uncoordinated	
Problems with hand-eye coordination	
Difficulty with concepts such as up, down, over, under	
Often bumps into things when walking	