This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-7.

ADOLESCENT INTAKE FORM (ages 12-17)

CLIENT INFORMATION

Name:____

Date of Birth: ______________________ Age: __________ ❒ Male ❒ Female

Physical Address: ____

Mailing Address: ____

Phone (Cell): ______________________________ Messages okay?__________

Phone (Home): ______________________________ Messages okay?__________

School: ______________________________ Grade: __________

Race/Ethnic Origin: ____

Religious Preference: ____

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 counseling?

____

____

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)

Have you ever used more than 1 chemical at the same time to get high? _________
Do you avoid family activities so you can use? _______
Do you have a group of friends who also use? _______
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

Are your parents married or divorced? ______________________
Do you think their relationship is good? (Y/N/Unsure)__________________
If your parents are divorced, whom do you primarily live with? _____________
How often do you see each parent? Mom_________% Dad ___________%.
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 check any family concerns that your family is currently experiencing*)

Fighting	Disagreeing about relatives
Feeling distant	Disagreeing about friends
Loss of fun	Alcohol or Drug use
Lack of honesty	Trauma
Medical Concerns	Infidelity (couple)
Education problems	Divorce/separation
Financial problems	Issues regarding remarriage
Death of a family member	Birth of a child
Inadequate health insurance	Job change or job dissatisfaction
Inadequate housing/feeling unsafe	Other

Other concerns not listed above ____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation. Are you happy with the amount of friends you have? (Y/N)________________
Have you ever been bullied? (Y/N) ____________

Are your parents happy with your friends? (Y/N)_____________________
Are involved in any organized social activities (e.g. sports, scouts, music)?
____

SCHOOL HISTORY

Do you like school? (Y/N)______________
Do you attend regularly? (Y/N)_____________
What are your current grades? _____________________
Do you feel you are doing the best you can at school? (Y/N) ________________________

Is there anything else you would like me to know: _______________________________________
____
____

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: ___________
Mother's/Guardian's Name: ______________________ Phone Contact:____________________
Mother's/Guardian's Physical Address: ____
Mother's/Guardian's Mailing Address: ____
Father's/Guardian's Name: ______________________ Phone Contact:____________________
Father's/Guardian's Physical Address: ____
Father's/Guardian's Mailing Address: ____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with 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?
____
____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor?❒Yes❒No
If Yes, where: ____

April Blair, M.A. M.F.T. #113278
15300 Ventura Blvd Suite 203
Sherman Oaks, California 91403

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?
____
____
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 _________
Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _______

If so, please describe: ____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?
Yes ___ No ___ If yes, describe:
____
____
Did your child have health problems at birth? Yes _____ No ______ If yes, describe:
____
____
Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ___ No ___ Not sure_____ If yes, describe:
____
____
Did your child have any unusual behaviors or problems prior to age 3?
Yes ___ No ___ Not sure_____ If yes, describe:
____
____
Has your child experienced emotional, physical, or sexual abuse?
Yes ____ No ____ Not sure _____ If yes, 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.
____
____

FAMILY HISTORY

(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.)
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 _________________
Assessment of current relationship if applicable: Poor_____ Fair_______ Good_________
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 _________________
Assessment of current relationship if applicable: Poor_____ Fair_______ Good_________

PARENT'S MARITAL STATUS

❒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 _____%

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 or Drug use
Lack of honesty	Trauma
Medical Concerns	Infidelity (couple)
Education problems	Divorce/separation
Financial problems	Issues regarding remarriage
Death of a family member	Birth of a child
Inadequate health insurance	Job change or job dissatisfaction
Inadequate housing/feeling unsafe	Other

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

____

____

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

____

____

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)

____

____

Is there anything else you would like me to know: ______________________________

____

____