

CROSSVILLE COUNSELING CENTER
Adolescent Intake Form

Please print clearly. Please fill out form completely.

Readmit: Yes No

Date: _____ Client's Social Security #: _____ Case #: _____

Client's Legal Last Name: _____ Legal First Name: _____ M.I. _____

Address: _____ City: _____ State: _____ Zip: _____

Tel. (home) _____ (work) _____ (cell) _____

OK to leave messages? Home: Yes No Work: Yes No Cell: Yes No

Email Address: _____ Can Emails be sent: Y N

Birthdate: ____/____/____ Age: ____ Gender: F M Race: _____

Name of Parent/Guardian: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Form Completed By: _____ (Please submit address below, if different from above)

Address: _____ City: _____ State: _____ Zip: _____

Emergency Information:

In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name (2) _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Care Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Can your PCP be contacted for continuity of care, if needed: Yes Refused

Employment Information (If client is a child too young to work, use parents employment)

Client/Guardian: Place _____ Occupation _____ Hrs. _____

Parent: Place _____ Occupation _____ Hrs. _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____

Contract/ID# _____ Contract/ID# _____

Group/Acct# _____ Group/Acct# _____

Subscriber _____ Subscriber _____

Subscriber Social Security # _____ Subscriber Social Security # _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

Client's relationship to Subscriber _____ Client's relationship to Subscriber _____

Self Son/Daughter Other Self Son/Daughter Other

Referral Source

How did you hear of Crossville Counseling? _____

Address _____ City _____ State _____ Zip _____

Phone _____

Primary reason(s) for seeking services:

Anger management Anxiety Coping Depression
 Eating Disorder Fear/phobias Mental confusion Sexual concerns
 Sleeping problems Addictive behavior Alcohol/drugs Past Trauma
 Self-injury Self-esteem Behavioral Hyperactivity
 Other mental health or behavioral concerns (specify) _____

How long have these symptoms been present? _____

Any Additional information that would assist in understanding your concerns or problems? _____

How much family involvement would you like to see in therapeutic process? _____

Describe how the above symptoms impair your ability to function effectively (e.g., socially, occupationally, academically, emotionally, physically) _____

Stressors (Check all that apply)

- Arrest
- Court trial
- Crime (witness/victim)
- Upcoming surgery
- Conflict w/teacher
- Conflict w/parent
- Conflict w/sibling
- Breakup of relationship
- Birth of a sibling
- Change in residence
- Change of school
- Death of a sibling
- Death of a friend
- Death of parent
- Death of spouse
- Death of grandparent
- Divorce of parents
- Family conflict
- Illness (child/parent)
- Family financial status
- Parental Discord
- Personal Injury
- Abuse (physical, sexual, verbal)

Counseling/Prior Treatment History (Information about client past and present)

	Yes	No	When	Where	Overall experience
Mental Health Counseling	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/Alcohol treatment	___	___	_____	_____	_____
M.H. Hospitalizations	___	___	_____	_____	_____
Involvement w/self-help	___	___	_____	_____	_____
Groups (AA, al-alnon, etc.)	___	___	_____	_____	_____

Any immediate family in treatment currently? If yes, whom and where? _____

Previous mental health diagnosis(es): _____

What areas of your life are being affected by the above?

Social

- Unable to form or maintain friendships
- Withdrawal from family and friends (excessive desire to be alone)
- Increased conflict with others
- Verbally aggressive
- Loss of interest in activities
- Phobias
- Argues with family/friends
- Lack of assertiveness
- Conflict with authority
- Excessive dependency
- Poor judgment
- Lack of communication
- Physical aggression
- Social isolation

Occupational (if client works)

- Unable to maintain job
- Absenteeism
- Conflicts with co-workers
- Tardiness
- Reduced productivity
- Disciplinary action for poor performance

Physical

- Decreased energy/fatigue
- Difficulty getting out of bed or insomnia
- Decreased/Increased appetite
- Substantial weight loss or gain
- Frequent illness
- Physical complaints (headaches, stomachaches, etc.)

Academic

- Failing grades
- Detention
- Reduced productivity at school
- Tardiness
- Suspensions
- Fighting/conflicts with student/teachers
- Overachievement
- Underachievement
- Refusal to go to school
- Daydreaming in class
- Truancy
- Difficulty remembering assignments
- Disruptive in class
- Excessively shy
- Incomplete assignments/Careless mistakes
- Honors classes
- Organized
- Special Ed. (LD or ADHD or MR or Visual/Audio Impaired)
- Self-directed
- Responsible
- Cooperative

Case # _____

Behavioral/Emotional

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Affectionate | <input type="checkbox"/> Crying spells | <input type="checkbox"/> Irritability/mood swings | <input type="checkbox"/> Anger/rage |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Blinking/Jerking | <input type="checkbox"/> Verbally Aggressive | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Bizarre behavior | <input type="checkbox"/> Physically Aggressive | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Attachment to dolls | <input type="checkbox"/> Avoids adults | <input type="checkbox"/> Bullies, threatens | <input type="checkbox"/> Concentration problems |
| <input type="checkbox"/> Worries excessively | <input type="checkbox"/> Careless, reckless | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Clumsy |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Computer addiction | <input type="checkbox"/> Emotional breakdowns |
| <input type="checkbox"/> Defiant | <input type="checkbox"/> Depression | <input type="checkbox"/> Destructive | <input type="checkbox"/> Emotionally overwhelmed |
| <input type="checkbox"/> Difficulty speaking | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Enthusiastic |
| <input type="checkbox"/> Expects failure | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Excessive masturbation | <input type="checkbox"/> Fearful |
| <input type="checkbox"/> Frequent injuries | <input type="checkbox"/> Frustrated easily | <input type="checkbox"/> Gambling | <input type="checkbox"/> Generous |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Head banging | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Hurts animals | <input type="checkbox"/> Imaginary friends | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Lazy |
| <input type="checkbox"/> Learning problems | <input type="checkbox"/> Lies frequently | <input type="checkbox"/> Listens to reason | <input type="checkbox"/> Loner |
| <input type="checkbox"/> Low self-esteem | <input type="checkbox"/> Messy | <input type="checkbox"/> Moody | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Obedient | <input type="checkbox"/> Often sick | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Over active |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Phobias | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Quarrels | <input type="checkbox"/> Sad | <input type="checkbox"/> Selfish |
| <input type="checkbox"/> Separation anxiety | <input type="checkbox"/> Sets fires | <input type="checkbox"/> Sexual addiction | <input type="checkbox"/> Sexual acting out |
| <input type="checkbox"/> Shares | <input type="checkbox"/> Sick often | <input type="checkbox"/> Short attention span | <input type="checkbox"/> Shy, timid |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Slow moving | <input type="checkbox"/> Soiling | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Steals | <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Suicidal threats | <input type="checkbox"/> Suicidal attempts |
| <input type="checkbox"/> Talks back | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Thumb sucking | <input type="checkbox"/> Tics or twitching |
| <input type="checkbox"/> Unsafe behaviors | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Other |

Please describe any of the above (or other) concerns: _____

Education

Current School _____ School Phone Number _____
Type of school Public Private Home Schooled Grade _____ (if summer grade just completed)
Has client ever been held back? Yes No Describe: _____
Which subjects does client enjoy in school? _____
Which subjects does client dislike in school? _____
What are client's typical grades in school? _____
Have there been any recent changes in grades? _____
Has child been tested psychologically? Yes No Where/When: _____

Parental Information

With whom does the child live at this time? _____
Parent's current relationship status:
 Single Divorce in process Unmarried, living together Legally married
 Separated Divorced Widowed Engaged Never married
Give date of any type of separation: _____ Client's age at time of separation: _____
Who has legal custody of client: _____
Is there any significant information about the parents' relationship or treatment toward the child that might be beneficial in counseling? Yes No If Yes, describe _____

Client's Mother

Name _____ Age _____ Occupation _____ FT PT
Where employed _____ Work telephone _____
Mother's Highest level of education _____ Mother remarried # of times: _____
Is there anything notable, unusual or stressful about the child's relationship with the mother? _____

How is the child disciplined by the mother (e.g. grounding, spanking)? _____
For what reason is the child disciplined by the mother? _____

Client's Father

Name _____ Age _____ Occupation _____ FT PT
Where employed _____ Work telephone _____
Father's Highest level of education _____ Father remarried # of times: _____
Is there anything notable, unusual or stressful about the child's relationship with the father? _____

How is the child disciplined by the father (e.g. grounding, spanking)? _____
For what reason is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

<u>Name of Siblings</u>	<u>Age</u>	<u>Gender (M/F)</u>	<u>Lives</u>	<u>Quality of relationship with client</u>		
_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	_____	<input type="checkbox"/> Home <input type="checkbox"/> Away	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good

<u>Others in the home</u>	<u>Age</u>	<u>Gender (M/F)</u>	<u>Relationship</u>	<u>Quality of relationship with client</u>		
_____	_____	_____	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	_____	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good
_____	_____	_____	_____	<input type="checkbox"/> poor	<input type="checkbox"/> average	<input type="checkbox"/> good

Special circumstances (e.g., raised by person other than parent) _____

Childhood/Adolescent History

Pregnancy/Birth

Has the child's mother had any occurrences of miscarriages or stillborns? Yes No
Was the pregnancy with client planned? Yes No Length of pregnancy _____
Mother's age at client's birth: _____ For Mother - Child # _____ of _____ total children
Father's age at client's birth: _____ For Father - Child # _____ of _____ total children
While pregnant did the mother smoke? Yes No If Yes, what amount _____
Did the mother use drugs or alcohol? Yes No If Yes, what type/amount _____
While pregnant, did the mother have any medical/emotional difficulties? (e.g. surgery, hypertension, medication) Yes No If Yes, describe: _____
Length of labor _____ Induced Yes No Caesarean? Yes No
Baby's birth weight: _____ Baby's birth length: _____
Describe any physical/emotional complications with the delivery: _____
Describe any complications for the mother or baby after birth: _____
Length of hospitalization Mother _____ Baby _____

Infancy/Toddlerhood (check all that apply)

- Breast fed Milk allergies Vomiting Diarrhea
- Bottle fed Rashes Colic Constipation
- Not cuddly Cried often Rarely cried Overachieve
- Resisted solid food Trouble sleeping Lethargic Irritable when awakened

Developmental History (Please note the age at which the following behaviors took place)

Sat alone _____ Dressed self _____
 Took 1st steps _____ Tied shoe laces _____
 Spoke words _____ Rode two-wheeled bike _____
 Weaned _____ Dry during day _____
 Fed self _____ Dry during night _____
 Attended Infant Day Care: ___ Yes ___ No Attended Preschool ___ Yes ___ No
 Attended Kindergarten (age) _____ Attended 1st grade (age) _____
 Compared with others in family, client's development was ___ Slow ___ Average ___ Fast

Age for following developments (fill in where applicable)

Began puberty _____ Menstruation _____
 Voice change _____ Breast development _____
 Issues that affected child's development (e.g. inadequate nutrition, neglect, several moves, foster care)

Any history of being abused by others? ___ No ___ Yes If Yes, what type(s) of abuse?
 ___ Emotional ___ Sexual ___ Physical ___ Verbal ___ Other, describe _____
 Client's age when abuse occurred: _____

Most recent examinations

<i>Type of examination</i>	<i>Date of most recent visit</i>	<i>Results</i>
Physical	_____	_____
Dental	_____	_____
Vision	_____	_____
Hearing	_____	_____

Immunization record (Please add date that vaccinations occurred)

	2-3 Months	4-5 Months	6-11 Months	12-15 Months	12-18 Months	4-6 Years
DTP/Dta/DT						
Polio						
Hib						
MMR						
Varicella						

Child's Peer Relationships

___ Spontaneous ___ Follower ___ Leader ___ Difficulty making friends
 ___ Makes friends easily ___ Long-time friends ___ Shares easily ___ Other: _____

Social Skills: ___ Good ___ Average ___ Poor

Who handles responsibility for your child in the following areas?

School ___ Mother ___ Father ___ Shared ___ Other (specify) _____
 Health ___ Mother ___ Father ___ Shared ___ Other (specify) _____
 Problem Behavior ___ Mother ___ Father ___ Shared ___ Other (specify) _____
 Discipline Techniques: _____

Cultural/Ethnic

To which cultural or ethnic group do you belong? _____
 Are you experiencing any problems due to cultural or ethnic issues? ___ Yes ___ No
 If Yes, describe _____
 Other cultural/ethnic information _____

Spiritual/Religious

How important to you are spiritual matters to you? ___Not at all ___Little ___Moderate ___Much

Are you affiliated with a spiritual or religious group? ___Yes ___No

If Yes, describe _____

Were you raised within a spiritual or religious group? ___Yes ___No

If Yes, describe _____

Would you like your spiritual/religious beliefs incorporated into the counseling? ___Yes ___No

If Yes, describe _____

Client's Current Legal Status

Is your child mandated for treatment? ___Yes ___No

If Yes, explain: _____

Are you involved in any active cases (traffic, civil, criminal)? ___Yes ___No

If Yes, please describe and indicate the court and hearing/trial dates and changes _____

Are you presently on probation or parole? ___Yes ___No

If Yes, please describe _____

Do you have a DCS Worker? ___Yes ___No Why? _____

DCS Name: _____ Phone: _____

Client's Past Legal History

Traffic violations ___Yes ___No DWI, DUI, etc. ___Yes ___No

Criminal involvement ___Yes ___No Civil involvement ___Yes ___No

If you responded Yes to any of the above, please fill in the following information.

Charges	Date	Where (city)	Results
_____	_____	_____	_____
_____	_____	_____	_____

Leisure/Recreational/Interests/Social

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, social organizations, etc.)

Activity	How often now?	How often in the past?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutrition

Meal	How often	Typical foods eaten	Typical amount eaten
Breakfast	___/week	_____	_____
Lunch	___/week	_____	_____
Dinner	___/week	_____	_____
Snacks	___/week	_____	_____

Additional comments on nutrition: _____

Medical/Physical Health Condition (Check any problem areas client/family has or has had)

C=Client MO=Mother FA=Father S=Sibling GM=Grandmother GF=Grandfather O=Other blood relative

Condition	Currently	In Past	Never	Condition	Currently	In past	Never
Abortion				Loss of consciousness			
Anemia				Memory loss			
Appetite change				Numbness			
Arthritis				Pain (daily, longer than 2 weeks)			
Asthma				Palpitations			
Back pain				Paralysis			
Blood in stool				Rheumatic fever			
Blurred vision				Seizures			
Caffeine use				Shortness of breath			
Chest pain				Skin disease			
Chicken pox				Sleep apnea			
Chronic cough				Sleep difficulties			
Colitis or irritable bowel				Stroke or TIA			
Confusion or disorientation				Swallowing difficulty			
Constipation				Dental problems			
Diabetes				Thyroid disease			
Diarrhea				Tuberculosis			
Dizziness				Ulcers or indigestion			
Emphysema				Urination difficulty			
Fainting				Sexually transmitted disease			
Glaucoma				Weakness			
Head injury				Recent Weight gain			
Headaches (frequent)				Recent Weight loss			
Hearing loss				Malnutrition			
Heart disease				Epilepsy			
Miscarriage				HIV/AIDS			
Infertility				Hepatitis			
Scoliosis				Energy level change			
Multiple sclerosis				Other			

Do any of these illnesses significantly challenge or limit client's ability to function at school or at home?
 If yes, please provide details:

List any current health concerns: _____

List any recent health or physical changes: _____

Does client have any physical/psychological disabilities? ___Yes ___No

Please list all of client's current prescription and non-prescription (over-the-counter) medications:

Name of your current medicine	What do you use it for?	When did you begin taking it?	What is the strength of each tablet or capsule	What dose do you take, and how often?	When was the most recent dosage change?	Prescribing Doctor

Please list all medication that client has taken in the past.

Name of your previous medicine	What did you use it for?	How long did you take it?	When did you stop taking it?	Why was it stopped?	Did the medicine cause any problems?	Prescribing Doctor

Describe client's overall compliance with the above medications _____

Please list all nutritional and herbal supplements that client currently takes: _____

Medication Allergies _____

Have you ever had any bad reactions (made you feel worse) to prior medications (if so, specify):

Do you (client) feel suicidal at this time? ___Yes ___No

If Yes, explain _____

Do you (client) feel homicidal at this time? ___Yes ___No

If Yes, explain _____

Have you ever felt homicidal/suicidal? ___Yes ___No When? _____

Was treatment sought? _____

Are you currently involved in any risk taking behaviors? ___Yes ___No

Please describe _____

List family history of mental illness/substance abuse:

Mother=MO Father=FA Sibling=S Grandmother=GM Grandfather=GF

Family History of:	Currently	In the Past	Never
Substance Abuse			
Anxiety			
Depression			
Manic Depression (Bipolar)			
Suicide Attempt			
Death by suicide			
Nervous Breakdown			
Addictive Behaviors (eating, sexual, etc.)			
Psychiatric Hospitalizations			

Do any of these illnesses significantly challenge or limit client's ability to function at work or home?
If yes, please explain: _____

Chemical Use History – Have you EVER used any of the following?

Drug	Method of use/amount	Frequency of use	Age of first use	Age of last use
Alcohol				
"Meth"amphetamines				
Barbiturates				
Valium/Librium				
Cocaine/Crack				
Heroin/Opiates				
Marijuana				
PCP/LSD/Mescaline				
Inhalants				
Xanax, Klonopin, Ativan				
Caffeine				
Nicotine				
Over-the-Counter				
Prescription drugs				
Other				

Substance(s) of preference

1. _____
2. _____
3. _____
4. _____

Describe when and where you typically use substances: _____

Describe any changes in your use pattern: _____

Case # _____

Describe how your use has affected your family or friends (include their perceptions of your use):

Reason(s) for use:

Addicted Build confidence Escape Self-medication
 Socialization Taste Other: _____

How do you believe your substance use affects your life? _____

Who or what has helped you in stopping or limiting your use? _____

Has your use of alcohol or drugs interfered with your obligations at work?

Has your use of alcohol or drugs interfered with your obligations at school?

Has your use of alcohol or drugs interfered with your obligations at home?

Have you used alcohol or drugs while driving a vehicle or operating machinery?

Have you ever been arrested as a result of drinking or using drugs?

Have you continued to use alcohol/drugs despite having problems caused by the effects of alcohol/drugs?

Have you ever used more alcohol/drugs in order to achieve the desired effect?

Has there become a markedly diminished effect with the continued use of the same amount of the substance?

Have you ever needed to take a drink or use a drug in the morning in order to relieve a hangover?

Have you ever used substances in larger amounts or over a longer period of time than was initially intended?

Have you attempted to cut down or control the amount of drinking or drug use without success?

Have you spent a great amount of time in activities necessary to obtain the alcohol or drugs?

Have you given up or reduced important social, occupational, or recreational activities because of your use of alcohol or drugs?

Have you continued to use alcohol or drugs despite knowing physical, psychological, or legal problems are likely to occur?

Is there anything further that you would like to add in regard to your overall history?

Goals for Therapy: Please list what therapeutic outcomes you would like to have at discharge.

By signing below I am indicating that the above information is accurate to the best of my ability.

Client Signature (age 16 and older must sign)

Date

Parent/Guardian Signature

Date

For Office Use Only:

Therapist's Signature/Credentials

Date

Revised 06/25/2011

Case # _____