To be completed by client. Please answer all questions. Use the back to explain any answer if necessary. You will have a chance to explain any answers during our intake session.

Adolescent Intake Form

Name: _____ Today's date:_____

Nickname/Name you want to be called: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Birth Date: _____ Age: _____ Gender: _____

School:_____ Grade: _____

Is it OK to send confidential information to your e-mail address? □ Yes □ No

Is it OK to communicate through texting? □ Yes □ No

Living Arrangement – With whom do you currently live?

□ BOTH Parents/Legal Guardians □ ONE Parent/Legal Guardian

□ Other Family Members, List: _____

Parents'/Legal Guardian's Name:_____

Parents'/Legal Guardian's Phone & Email: _____

Are you currently employed? □ Yes □ No. IF yes, where? _____

Religious Affiliation (If Applicable): _____

Did you participate in the decision to start counseling? □ Yes □ No

Previous History

Please describe what brings you to counseling at this time. _____

_____

_____

What do you hope to gain through counseling?

_____

_____

What have you already done to deal with the difficulties?

_____

_____

Have you had previous psychological counseling or psychiatric help?

Please check all that apply.

□ **Individual counseling? If yes, when and where?**

_____

_____

□ **Group/Family Counseling? If yes, when/where?**

_____

_____

□ **Hospitalization(s)? If yes, when/where?**

_____

_____

List any medications and dosages that pertain to your mental well-being:

_____ _____

_____ _____

List any significant health problems for which you have been treated in the past and then place a check by those problems for which you are currently being treated:

_____

_____

List any serious or chronic illness, operations, or traumatic accidents you have had:

_____

_____

Are you currently, or have you at any time within the last 12 months been under the care of a physician? □ Yes □ No

If so, for what condition?_____

_____

What are your biggest strengths? _____

_____

Do you exercise? □ Yes □ No. If yes, for how long and how many times per week?_____

Do you smoke? □ Yes □ No. If yes, what do you smoke? _____**How often?**_____

Do you consume alcohol? □ Yes □ No If yes, quantity per: Day _____ Week _____

Do you take any non-prescribed (recreational) drugs? □ Yes □ No If yes, what and how often? _____

_____

Interactions between client and counselor are confidential. Unless I have permission from you, what we talk about will be private; I will not discuss it with anyone else. Our discussion will be private and confidential, even if you don't mind your parents knowing about anything that we talk about

There are four major exceptions to confidentiality that Colorado law requires all mental health professionals to report when there exists:

1. Incidence(s) of child or elder abuse or neglect.
2. Intent to commit suicide.
3. Threats to do harm to yourself or another person.
4. Court order

Client's (signature) _____ Date:_____

IF you are under the age of 15 years old, must provide guardian's consent for mental health services.

Parent(s)/Guardian(s)_____Date: _____

Counselor's (signature) _____ Date _____