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A Full Service Behavioral Health Practice Specializing in the Strategic Integration of Medical and Psychological Care

Adolescent Intake Form

Date _____

Name _____ Date of Birth _____ Age _____

Present Address _____ City _____ State ____ Zip _____

Permanent Address _____ City _____ State ____ Zip _____

Telephone Home _____ Work _____ Mobile _____

Social Security # _____

Name of the person(s) with whom you now live? _____

Relationship Father ____ Mother ____ Guardian ____ Other ____

Person to contact in case of an emergency _____

Address _____ Telephone _____

FAMILY INFORMATION

Mother's Name _____ Birth Date _____ Age _____

Occupation _____ Marital Status _____

Address _____

Telephone Home _____ Work _____ Mobile

Father's Name _____ Birth Date _____ Age _____

Occupation _____ Marital Status _____

Address _____

Telephone Home _____ Work _____ Mobile _____

Names of Brothers and Sisters

1. _____ Age _____ Gender _____
2. _____ Age _____ Gender _____
3. _____ Age _____ Gender _____
4. _____ Age _____ Gender _____

EDUCATIONAL INFORMATION

School Attended _____ Grade _____

What are your usual grades? _____

Do you enjoy school? Yes ____ No ____

What has been your biggest problem at school? _____

Do you get along with your teachers? Yes ____ No ____

Do you get along with other students a school? _____

Discuss any other academic or behavioral problems you have had at school _____

CONCERNS/PROBLEMS INFORMATION

Have you previously had counseling/therapy? Yes ____ No ____ If so, when? _____

With Whom? _____ For how long? _____

Why did you stop? _____

In your own words, briefly explain the problem(s) which prompted you or your parents to seek counseling at this time. _____

Have there been times when the problems got better or disappeared? Yes ____ No ____ If so, when? _____

What do you think helped? _____

Were there times when the problem was especially bad? Yes ___ No ___ If so, when? _____

What do you think made worse? _____

Are there other people who play a role in causing your problem? Yes ____ No ____ Helping your problem? Yes ____ No ____

Explain briefly _____

PERSONAL INFORMATION

Explain your spiritual interests _____

What do you enjoy doing in your spare time? _____

How were you disciplined as a child? _____

How are you disciplined now? _____

If you could change something about your family, what would you change? _____

Name one goal you would like to reach in counseling _____

PROBLEM AREAS

Problem Areas: In the following list, please place a check next to each item which indicates an area of concern to you. Please place two checks by items which are most important (you may add comments.)

Anxiety	Unable to trust others
Depressed mood	Change in eating habits
Guilt feelings	Can't stand up for myself
Overactivity	Can't say "no" to others
Weight Loss	Lonely/too few friends
Headaches	Poor adjustment to school
Feelings of inferiority	Bad temper/anger problems
Loss of interest	Shy or awkward with others
Poor sleeping	Stomach or bowel disturbance
Repetitive Ideas	Unfairly treated by others
Thoughts of suicide	Drinking or drug problems
Wish to hurt others	Rely too much on others
Parent's marital relationship	Suspicious of others
Financial problems	Recent loss of someone
Lonely/too few friends	Sexual problems/concerns
Unhappy most of the time	Family quarreling
Problem with brother or sister	Fear of things or situations
Troubling memories	Religious/spiritual concerns
Inability to relax	Cardiovascular/heart problems
Memory difficulties	Alcohol/drug problem in family
Lack of confidence	Unusual/strange experiences
Can't make a decision	Outbursts of anger
Aggressiveness	Stress from recent event
Daydreaming	Divorce/separation difficulty
Eating problems	Troubling habits/thoughts
Bitterness/resentment	Feeling rejected by family
Periods of overactivity	Disturbing childhood memories
Difficulties with opposite sex	Fighting/Arguing with others
Other _____	

Signature _____ Date _____

Provider _____ Date _____