# 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 _____

**ONCERNS/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 see 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 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 on 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
- [ ] [ ] Depressed mood
- [ ] [ ] Guilt feelings
- [ ] [ ] Overactivity
- [ ] [ ] Weight Loss
- [ ] [ ] Headaches
- [ ] [ ] Feelings of inferiority
- [ ] [ ] Loss of interest
- [ ] [ ] Poor sleeping
- [ ] [ ] Repetitive Ideas
- [ ] [ ] Thoughts of suicide
- [ ] [ ] Wish to hurt others
- [ ] [ ] Parent's marital relationship
- [ ] [ ] Financial problems
- [ ] [ ] Lonely/too few friends
- [ ] [ ] Unhappy most of the time
- [ ] [ ] Problem with brother or sister
- [ ] [ ] Troubling memories
- [ ] [ ] Inability to relax
- [ ] [ ] Memory difficulties
- [ ] [ ] Lack of confidence
- [ ] [ ] Can't make a decision
- [ ] [ ] Aggressiveness
- [ ] [ ] Daydreaming
- [ ] [ ] Eating problems
- [ ] [ ] Bitterness/resentment
- [ ] [ ] Periods of overactivity
- [ ] [ ] Difficulties with opposite sex
- [ ] [ ] Other _____

- [ ] [ ] Unable to trust others
- [ ] [ ] Change in eating habits
- [ ] [ ] Can't stand up for myself
- [ ] [ ] Can't say "no" to others
- [ ] [ ] Lonely/too few friends
- [ ] [ ] Poor adjustment to school
- [ ] [ ] Bad temper/anger problems
- [ ] [ ] Shy or awkward with others
- [ ] [ ] Stomach or bowel disturbance
- [ ] [ ] Unfairly treated by others
- [ ] [ ] Drinking or drug problems
- [ ] [ ] Rely too much on others
- [ ] [ ] Suspicious of others
- [ ] [ ] Recent loss of someone
- [ ] [ ] Sexual problems/concerns
- [ ] [ ] Family quarreling
- [ ] [ ] Fear of things or situations
- [ ] [ ] Religious/spiritual concerns
- [ ] [ ] Cardiovascular/heart problems
- [ ] [ ] Alcohol/drug problem in family
- [ ] [ ] Unusual/strange experiences
- [ ] [ ] Outbursts of anger
- [ ] [ ] Stress from recent event
- [ ] [ ] Divorce/separation difficulty
- [ ] [ ] Troubling habits/thoughts
- [ ] [ ] Feeling rejected by family
- [ ] [ ] Disturbing childhood memories
- [ ] [ ] Fighting/Arguing with others

Signature _____ Date _____

Provider _____ Date _____