

Client Intake Form- ADOLESCENT

Today's Date:

How did you hear about us?

Personal Information

First Name:	MI:	Last Name:		
Birthdate:	Age:	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Address:	City:	State:	Zip:	

Contact Information

Mobile:	<input type="checkbox"/> I give permission to leave a message at this number. <input type="checkbox"/> I DO NOT give permission to leave a message at this number
Email:	<input type="checkbox"/> I give permission to be contacted by email

What is your preferred method of contact? (mark only one): Mobile Phone Email

Parent/Guardian Information

Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Co-habiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other		
Father:	Address:	Phone:
Mother:	Address:	Phone:

Emergency Contact Information

Name:	Relationship:
Mobile:	

Others In the Home

Relationship Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Co-habiting <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
Spouse/Partner:	Children's Names/Ages:

Insurance Information

Insurance Provider:	Employer:
Policy Number/Member ID:	Group Number:
Policy Holder's Name:	DOB: <input type="checkbox"/> Male <input type="checkbox"/> Female
Policy Holder's Address:	Phone Number:
Client's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Employee Assistant Program Provider:	Authorization: # of Visits:

Agreements

Please initial next to each then sign below.

HIPAA AND YOUR PROTECTED HEALTH INFORMATION

_____ You have read the HIPAA and Protected Health Information agreement and agree to its term.
You acknowledge you have received this notice of privacy practices.

INFORMATION DISCLOSURE AND INFORMED CONSENT FORM

_____ You have read and reviewed this informed consent. You understand and agree to all of the terms as they are written including fees, no-show fee and children as minors. In addition you have been offered a copy of this form for your own records.

CLIENT RIGHTS

_____ You have read, understand and accept my rights as a client of Kara Kang, LCPC regarding both privacy practices and the scope of services available.

Authorizations

AUTHORIZATION TO TREAT A MINOR CHILD

_____ You have read the authorization, agree to its concerns and hereby consent for Kara Kang, LCPC to provide services to the minor child listed below.

MANAGED CARE INSURANCE PLANS RELEASE OF INFORMATION

_____ You have read the information regarding the release of protected health information and authorize Kara Kang, LCPC to coordinate your care with your insurance plan and primary care physician.

Client Name (printed): _____ Date: _____

Client OR Parent/Guardian Signature: _____

Clinical History Form

SYMPTOMS SCREENER

For the questions below, select one option for each question that best represents your answer.

OVER THE PAST TWO WEEKS, HAS YOUR CHILD:	Not at all	1-2 days	3-5 days	Daily
Experienced sadness, weepiness, or crying spells?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt hopeless, pessimistic or discouraged about the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not been able to enjoy things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt tired, slowed down or had no energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lacked motivation or interest in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty falling asleep or frequent waking/sleeping too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty making decisions or concentrating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Experienced decreased/decreased appetite?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt guilty or worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt like you wanted to die, or wished you were dead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriously considered or planned to end your own life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt restless, worried, or nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had headaches, stomachaches or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much distress would you say these symptoms caused you?	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	

HAVE YOU EVER EXPERIENCED OR WITNESSED ANY OF THE FOLLOWING TRAUMATIC EVENTS?

Natural Disaster (flood, hurricane, tornado, earthquake, fire, industrial accident)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transportation accident (car, boat, train, or plane)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical assault as a child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical assault as an adult?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual assault/abuse as a child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexual assault/abuse as an adult?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Combat, exposure to a war-zone, or captivity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Life Threatening Illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sudden, unexpected death or injury of someone close to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Serious injury, harm, or death to someone else you caused or witnessed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experience re-occurring and unwanted flashbacks, nightmares or reminders of the event?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Made efforts to avoid thinking or talking about this event, or doing things that remind of it?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Felt less interest in people and things, a feeling of numbness, or trouble experiencing emotions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Felt nervous, jumpy or had a sense of heightened alertness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Had trouble with irritability, falling or staying asleep, or with concentrating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HISTORY OF RECREATIONAL DRUG USE

Amphetamines/Speed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Barbiturates	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Heroin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Narcotics (Vicodin, Oxy)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Cocaine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
LSD, Ecstasy, Bath Salts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Cannabis/Marijuana	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Benzodiazepines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
PCP	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:
Adderall (non-prescribed)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of First Use:	Age of last use:	Method:

In the past twelve months have you used drugs for anything other than medical reasons?
 Have you ever experienced withdrawal symptoms when you stopped taking drugs?

Yes No
 Yes No

ALCOHOL CONSUMPTION

Do you regularly drink alcohol (including beer or wine?)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How often do you typically drink?	<input type="checkbox"/> 2x per month or less	<input type="checkbox"/> Weekly <input type="checkbox"/> Daily
How often do you typically drink?	<input type="checkbox"/> 2x per month or less	<input type="checkbox"/> Weekly <input type="checkbox"/> Daily
Has your drinking ever caused problems between you and family members or close relationships?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you tried to cut back or stop drinking but not been successful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you drank alcohol and been hung over while working, going to school or taking care your children?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you missed or been late for work, school or other activities because you were drunk or hung over?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been in trouble with the law because of drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever experienced withdrawal symptoms when you stopped drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SELF-HARM

Have ever cut yourself or hurt yourself intentionally? Yes No **If yes describe:**

ADDITIONAL SYMPTOMS	Excellent	Above Average	Average	Some Problems	Major Problem
Overall School Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships with siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with peers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Participation in organized activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt guilty or worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt like you wanted to die, or wished you were dead?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seriously considered or planned to end your own life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt restless, worried, or nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had headaches, stomachaches or pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Briefly describe the reason(s) you are seeking counseling:

About how long have you been concerned about this: 1 month 2-3 months 6months 1 year Other

WHICH BEST DESCRIBES YOUR SOCIAL SITUATION?

- Supportive social network
 Makes friends easily
 Feeling lonely/isolated
 Few friends
 Conflict with peers/classmates
 Gets bullied
 Difficult sustaining friendships
 No friends
 Other/Describe:

FAMILY HISTORY

Has your child ever experienced parental separation, divorce, or death? Yes No

If the parents are separated or divorced, who has custody? Mother Father Joint Other

Please describe current custody/legal or foster child arrangements for this child:

Describe child's current family environment: who lives in the home, strengths, stressors, dynamics:

Please list child's sibling (including step-siblings):

Has your child ever experienced parental separation, divorce, or death? Yes No

Name	Age	M/F	Living in the home?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

PSYCHIATRIC HISTORY

HAVE CHILD USED COUNSELING SERVICES IN THE PAST Yes No

Name of Counselor	Primary Reason	Location	Outcome/Was it helpful?
-------------------	----------------	----------	-------------------------

Yes No

Yes No

HAVE YOUR CHILD HAD A PREVIOUS DIAGNOSIS OF:

Anxiety Depression Panic ADHD OCD Bipolar Anorexia Bulimia PTSD Alcoholism

HAVE YOUR CHILD EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS Yes No

When/Dates	Location	Purpose	Length of Stay
------------	----------	---------	----------------

HAVE YOUR CHILD EVER ATTEMPTED SUICIDE? Yes No **If Yes, then:**

Dates	Method	Lethality (required medical intervention?)
-------	--------	--

PSYCHIATRIC HISTORY

MOTHER	FATHER	SIBLINGS	EXTENDED FAMILY/ GRANDPARENTS
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Alcohol Addiction
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Anxiety
<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD	<input type="checkbox"/> OCD
<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression	<input type="checkbox"/> Depression
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Bipolar
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> PTSD	<input type="checkbox"/> PTSD	<input type="checkbox"/> PTSD	<input type="checkbox"/> PTSD
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anger Management
<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Personality Disorder
<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Attempted Suicide	<input type="checkbox"/> Attempted Suicide
<input type="checkbox"/> Completed Suicide	<input type="checkbox"/> Completed Suicide	<input type="checkbox"/> Completed Suicide	<input type="checkbox"/> Completed Suicide
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

EDUCATIONAL HISTORY

Current School	Grade	Teacher
Past Schools	Grade	Teacher

MEDICAL HISTORY

PRIMARY CARE

Primary Care Physician: _____

Office Address: _____

Phone Number: _____

MEDICAL HISTORY

Current/Past Medical Conditions:

- | | | | | | |
|---|---|--|--|---------------------------------------|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches/
Migraines | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Shortness of
Breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Menstrual
Problems |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Hormone
Imbalance | <input type="checkbox"/> Dementia | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> High Blood
Pressure | <input type="checkbox"/> Seizure/Epilepsy | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Smoke |

Other:

Do you have allergies: YES NO List:

Are you currently taking medication: YES NO

Name of Medication	Dosage	Frequency	Purpose

FAMILY HISTORY OF ILLNESS/DISEASE

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other |

CURRENT PSYCHIATRIC CARE

Psychiatrist Developmental Therapy Case Management Service Coordination CBRS Other:

Name of provider/s**Location****Phone****CURRENT PSYCHIATRIC MEDICATION****Name of Medication****Dosage****Frequency****Purpose**