**ADOLESCENT INTAKE** – *To be filled out by Parent or Guardian*

***Parent/Guardian Information***

Name: _____ Date: _____

Home Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

May I call and leave messages at home? □ Yes □ No Work? □ Yes □ No Cell Phone? □ Yes □ No

Marital Status: □ S □ M □ D □ W No. of Marriages: _____ Date of Current Divorce/Sep. _____

If Divorced, Name of Other Custodial Parent: _____Phone: _____

Occupation: _____ Highest Level of Education: _____

Children(s) Name(s): _____ DOB: _____ □ M □ F

_____ DOB: _____ □ M □ F

_____ DOB: _____ □ M □ F

_____ DOB: _____ □ M □ F

How much contact per week do you have with the adolescent coming for treatment? _____

***Client Information (Adolescent Coming For Treatment)***

Name of Client: _____ DOB: _____

The Client is Currently Living With: _____ School and Grade: _____

Extracurricular Activities/Interests: _____

Medical History

How would you rate the client's current physical health? □Excellent □ Good □ Fair □ Poor

Is the client currently complaining of any physical problems? If Yes, Please Explain: _____

_____

Please list any medical conditions/disabilities/learning disabilities: _____

| Daily Medication(s)<br>Over the Counter or Prescription | Prescribing Physician |
|---|---|
| | |
| | |

Pediatrician/Family Physician: _____ Phone: _____

Counseling and Psychiatric History

Has the client had previous counseling? □ Yes □ No If yes, for how long? _____ When? _____

For what reason? _____ Name of Counselor: _____

Has the client ever been diagnosed or treated for any type of mental illness? If yes, what type? _____

Has anyone in the family ever been diagnosed with or treated for any type of mental illness? If yes, what type? _____

_____

---

***Reasons for Seeking Help***

What concerns about the client have brought you to counseling today? _____

_____

Where are these concerns causing the most problems? □ Home □ School □ Social □ Other

When did these concerns begin to be a problem? _____

What concerns about have been identified by others? _____

Please indicate which of the following are currently problems for the adolescent:

□ Crying Spells
□ Excessive Fear/Anxiety
□ Bullying/Picking Fights
□ Hearing Voices
□ Lack of Motivation
□ Decreased/Increased Appetite
□ Difficulty Making or Keeping Friends
□ Obsessions/Compulsions
□ Cutting
□ Hyperactivity
□ Refusal to Respond to Authority
□ Nightmares
□ Difficulty Separating from Specific Family Members
□ Tantrums
□ Lack of Self-Confidence
□ Loss of Interest in Usual Activities
□ Insomnia/Hypersomnia

Is there anything else that you would like for me to know today? _____

_____

_____

How did you hear about our counseling office? _____

**Emergency Contact*– Name: _____ Phone: _____**

**Relationship to the Child: _____**
***This person will only be contacted if there is a counseling related emergency and you (or the primary guardian) cannot be reached. Please discuss any concerns or questions you have about this with me.**