ADOLESCENT INTAKE

Name: _____ Date: _____

Age: _____ Grade/School: _____Birthday:_____

Address: _____ City/State/Zip: _____

Who are you presently living with?

_____

Extracurricular
Activities/Interests/Hobbies:_____

_____

_____

Whose idea was it for you to come to counseling today?

_____

Please Rate the Following Issues with a Number:

1 = Major Problem 2 = Sometimes a Problem 3 = Never a Problem

_____ Feeling accepted by my peers

_____ Making and keeping friends/Social life

_____ Getting along with my parents or other family members

_____ Worrying about issues in my life

_____ Making decisions

_____ Dealing with alcohol or drugs

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

_____ Self-Harm/Cutting

_____ Not Eating/Eating too much/Bingeing and Purging

_____ Other: _____

Have you been to counseling before? □ Yes □ No If yes, when? _____

For what reason?_____

Who is the person in your life whom you trust the most?

_____

What would you like to accomplish in counseling?_____