

ADOLESCENT CLIENT INTAKE FORM

This form may seem long. But the information on it will help us to better help you. Anything you put on this form is confidential unless it has to do with someone hurting herself or himself or someone else.

Adolescent Information

Name: _____ Date of First Visit: _____

Address: _____ City, State, Zip: _____

Gender: _____ Age: _____ Date of Birth: _____ Social Security #: _____

Home Phone: _____ OK to Call? _____ OK to Leave Message? _____

Parents or Legal Guardians: _____

With whom do you live? _____

Brought in for counseling by: _____ Relationship to you: _____

What school do you go to? _____ Grade: _____

Are you here because you want counseling or because someone else wants you to get counseling?
 I do: _____ Someone else does: _____

Check any of the symptoms that you are having:			
Depression	<input type="checkbox"/>	Feeling hopeless	<input type="checkbox"/>
Extreme sadness	<input type="checkbox"/>	Feeling tearful	<input type="checkbox"/>
Trouble concentrating	<input type="checkbox"/>	Change in sleeping habits	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>
Change in eating habits	<input type="checkbox"/>	Weight changes	<input type="checkbox"/>

(This space reserved for additional comments by clinician)

Feeling of extreme happiness		Problems getting along with friends or families	
Trouble going to school		Feeling stressed	
Lack of enjoyment of usual activities		Easily irritated	
Self-esteem problem		Feeling guilty	
Perfectionism		Feeling nervous	
Obsessions or compulsions		Sudden feelings of panic	
Feeling fearful		Muscle tension	
Physical complaints of pain		Acting violently	
Problems with anger		Thoughts about killing yourself or others	
Thoughts about hurting yourself or others			

Family Information

Your biological parents' names and ages:

Adults with whom you live:

List names and ages of biological brothers and sisters:

List names and ages of stepbrothers and sisters and other children living in the home:

Were you adopted?

Yes _____ No _____

If yes, at what age: _____

Have you ever lived in foster care or a similar living arrangement? Yes _____ No _____

If yes, at what age(s): _____

Has there been a death of a family member? Yes _____ No _____

If yes, what relationship was this person to you? _____

History

Do you have problems sleeping? Yes _____ No _____

If yes, please describe: _____

Do you have any problems with eating? Yes _____ No _____

If yes, please describe: _____

Do you have any unusual fears? Yes _____ No _____

If yes, please describe: _____

Have you ever had any major illnesses or injuries? Yes _____ No _____

If yes, please describe: _____

Have there been any critical events in your life? Yes _____ No _____

If yes, please describe: _____

Have you ever been sexually abused? Yes _____ No _____

Have you ever been physically abused? Yes _____ No _____

Have any of the other children in your home been abused? Yes _____ No _____

Have you ever witnessed violence between adults? Yes _____ No _____

How would you describe your interactions with kids your own age?

How would you describe your interactions with adults?

Have you gone through periods of major stress? Yes _____ No _____

Are you using alcohol or other drugs? Yes _____ No _____

If yes, please list:

Are you sexually active?

Yes _____ No _____

Have you done any behavior that has legal implications?
(shoplifting ,tagging, etc.)

Yes _____ No _____

Do you like to spend time on the internet?

Yes _____ No _____

How well do you do in school?

How well are you doing with your home life?

Counseling and Medical Information

Have you been in counseling before?

Yes _____ No _____

If yes, where and with whom? _____

How helpful was it? _____

Are you presently under any medical care for any illness?

Yes _____ No _____

If yes, please describe: _____

Have you ever been hospitalized?

Yes _____ No _____

If yes, please describe: _____

Are you taking any medications?

Yes _____ No _____

If yes, please list:

Has anyone in your family been diagnosed with a mental illness?

Yes _____ No _____

Has anyone in your family had a problem with alcohol or other drugs?

Yes _____ No _____

