ADOLESCENT INTAKE FORM

Adolescent Information Today's Date_____

Name _____ Age_____

Parent's & Guardian Information
Adolescent's Biological Parent(s): Married Divorced Separated Deceased Other

Name of Parent(s) or Guardian (s) of Minor: _____

Mom's Occupation_____Dad's Occupation_____

If divorce, how old was adolescent when it occurred? If so, please provide a copy of divorce decree & parenting plan.

Name of Step Parent(s) _____

Physician's Name: _____

Intake Questions for Minor

Issues of concern today

_____

_____

_____

Any previous counseling? Yes___ No___ With Whom_____

Why did you discontinue/stop?_____

What concerns brought you into counseling at that time? _____

If presently on medication(s), which one(s) _____

Are you or others concerned about your alcohol / drug use?

Adolescent Intake ~ page 2

Have you experienced physical abuse? Yes___ No___ Sexual Abuse? Yes___ No___
Emotional abuse? Yes___ No___

History of Hospitalization or Surgery_____

Are you currently in a romantic relationship? Yes___ No___

What school do you attend? _____Grade_____

What are your favorite subjects?_____

Any issues with school?_____

Who are your good friends?_____

_____

Are you involved in any activities at school? Yes___ No___

If so, what? _____

What do you consider to be your strengths?_____

What do you like most about yourself?_____

_____

Are you working? Yes___ No___
If so, where? _____# of hrs/wk_____

Religious / Spiritual Informaton

Do you consider yourself to be religious? Yes___ No___
If yes, how would you describe your faith?_____
If no, do you / your family consider yourselves to be spiritual? Yes___ No___

Is there any other information that you think is important for me to know about your and / or your family?_____

_____

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Have you ever experienced?

Extreme Depressed Mood	Yes___No___	Unexplained Losses of Time	Yes___No___
Wild Mood Swings	Yes___No___	Unexplained Memory Lapses	Yes___No___
Rapid Speech	Yes___No___	Alcohol / Substance Abuse	Yes___No___
Anxiety	Yes___No___	Eating Disorder	Yes___No___
Panic Attacks	Yes___No___	Body Image Problems	Yes___ No___
Phobias	Yes___No___	Repetitive Thoughts (obsessions)	Yes___No___
Sleep Disturbances	Yez___No___	Suicidal Thoughts	Yes___No___
Hallucinations	Yes___No___	Suicidal Attempt	Yes___No___

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? If Yes, List Family Member, e.g., sibling, parent, aunt, etc.

Difficult Family Member	Yes___No___	Alcohol / Substance Abuse	Yes___No___
Depression	Yes___No___	Eating Disorder	Yes___No___
Bipolar Disorder	Yes___No___	Learning Disability	Yes___No___
Anxiety Disorder	Yes___No___	Trauma History	Yes___No___
Panic Attacks	Yes___No___	Suicide Attempt(s)	Yes___No___

More Serious Mental Illness (please list)_____

Is there any other information that you think is important for me to know about you and / or your family?

_____

_____

_____

Empowering Individual & Relational Changes

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TREATMENT PLAN

Name_____Date_____

Please complete as best as you can. If you are unsure of your answers, bring your questions in and we will discuss at our first appointment.

Problems (Why I'm Here):

Goals (What I Want):

Indicators: (How do I know I'm making Progress?):

Estimate – How Long to Achieve Goals? _____

(We will figure this out together)

Likelihood (0-100%) of Achieving Goals?_____

(We will figure this out together)

Client Signature / Date

Katy Wait, MA LMFT / Date