

## 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:			(This space reserved for additional comments by clinician)	
Depression		Feeling hopeless		
Extreme sadness		Feeling tearful		
Trouble concentrating		Change in sleeping habits		
Memory problems		Lack of energy		
Change in eating habits		Weight changes		

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:

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Adults with whom you live:

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List names and ages of biological brothers and sisters:

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

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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 \_\_\_\_\_

