

**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		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 \_\_\_\_\_

