**ADOLESCENT INTAKE FORM**

This form is for minors age 12 and over. Information will be kept confidential from parents with exception of issues related to limits of confidentiality: child abuse or neglect, danger to self or others, regular substance use, regular self-injurious behavior.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F / Transgender / Gender Fluid / Non-Binary Preferred Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ Religion/Spirituality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade : \_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave voicemail? Yes/No Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave voicemail? Yes/No

OTHERS IN HOUSEHOLD  
Please list the following: (Name, Age, Date of Birth, Relationship, Occupation/Grade in School)



Current Concerns/Please list your reasons for counseling at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Mental Health Treatment (When and With Whom)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any guns in your home? Yes/No If yes, how are they stored? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been a victim of abuse (sexual, physical, emotional, financial)? If yes, please describe and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family History of Mental Health and Chemical Dependency Issues (eg. Depression, Anxiety, Bipolar, Psychosis, Victim of Abuse, Addiction):   
Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issues:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issues:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issues:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Issues:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check items that apply to your current and past condition(s):

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Current | Past |  | Current | Past |  | Current | Past |
| Drug or alcohol problems |  |  | Low motivation |  |  | Worry |  |  |
| Eating problems |  |  | Decreased need for sleep |  |  | Unusual thoughts |  |  |
| Sleeping more than normal |  |  | Excess energy/feeling wired |  |  | Hear voices others don’t |  |  |
| Sleeping less than normal |  |  | Mood swings |  |  | See things others don’t |  |  |
| Significant weight change |  |  | Confusion |  |  | Physical abuse |  |  |
| Life transitions |  |  | Elated Mood |  |  | Sexual abuse |  |  |
| Loss of appetite |  |  | Excessive spending |  |  | Financial problems |  |  |
| Feeling apart from others |  |  | Racing thoughts |  |  | Legal problems |  |  |
| Feeling worthless |  |  | Irritable |  |  | Sexual problems |  |  |
| Restlessness |  |  | Grandiose thoughts/plans |  |  | Health problems |  |  |
| Suicidal |  |  | Anger or explosiveness |  |  | Relationship problems |  |  |
| Suicide attempt(s) |  |  | Thoughts of harming others |  |  | Cutting |  |  |
| Low energy |  |  | Panic attacks |  |  | Trauma |  |  |

Self-Injury/Suicidal Thoughts/Homicidal Thoughts: Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol or Drug Use: Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exposure to Traumatic Event: Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing/Seeing Things That Others Do Not: Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tics: Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Repetitive Behaviors: Yes/No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_