Adolescent Intake Form

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In order to best serve you and your family, it is helpful for me to have some background information. Your cooperation in completing this questionnaire will enable me to do a better job and will make our time together more productive. Please complete this form collaboratively (adult/caregiver and teen). Please use two different colored pens and indicate who used which color.

Color of caregiver's pen: _____ Color of teen's pen: _____

Adolescent's Full Legal Name: _____ Today's Date: _____

Teen's Date of Birth: _____ Teen's Age: _____ Gender of teen: ☐ Male ☐ Female

Name of person completing this form:

☐ Biological parent ☐ Stepparent ☐ Adoptive parent ☐ Grandparent/relative ☐ Other

Name(s) of legal custodial parent(s): _____

Family's Home Address: _____

Home Phone: _____ May I leave a message? ☐ Yes ☐ No

Cell Phone: _____ May I leave a message? ☐ Yes ☐ No

Emergency Contact Name: _____

Emergency Phone: _____

Is anyone in your immediate family currently receiving psychiatric services, professional counseling or therapy elsewhere? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

Please explain: _____

Referred by: _____ May I thank them for the referral? ☐ Yes ☐ No

Teen only: Please circle the number that describes why you are coming to therapy. Please indicate if you are here by choice (10) or because your caregiver/parent organized therapy for you (1) or somewhere in between.

1 2 3 4 5 6 7 8 9 10

"I don't want to be here at all. My parent forced me to come."

"Therapy might be helpful for me but I'm not sure. I might have some things I'm interested in working on."

"It was my idea to come to therapy."

Please describe your reason for seeking counseling services. Please note when the challenges began and what you hope to accomplish in our work together. (It's okay if these are different for caregiver and teen.)

Teen: _____

_____

Caregiver/parent: _____

_____

Family Members:

Please list names, ages, and relations of each person living in the household:

Name	Age	Relation

Please list other members of immediate family (parents and siblings who do not live with the child):

Name	Age	Relation

Family History:

Do any family members struggle with the following challenges? (Family is defined as brother, sister, parent, grandparent, aunt, or uncle.)

Learning challenges/disability:	☐ Yes ☐ No	Family Member:	
Depression/Bipolar Disorder:	☐ Yes ☐ No	Family Member:	
Alcoholism/drug addiction:	☐ Yes ☐ No	Family Member:	
Anxiety/panic Attacks:	☐ Yes ☐ No	Family Member:	
Trauma (sexual assault, combat, abuse, etc.):	☐ Yes ☐ No	Family Member:	
Suicide attempts:	☐ Yes ☐ No	Family Member:	
Eating disorders (Anorexia/Bulimia):	☐ Yes ☐ No	Family Member:	
Hyperactivity/ADHD:	☐ Yes ☐ No	Family Member:	
Other behavior or emotional problems:	☐ Yes ☐ No	Family Member:	

Significant Medical Events

Have you (teen) experienced any major illnesses, operations, injuries, or allergies? ☐ Yes ☐ No

Event: Age of Teen:

Family's response to this event:

Event: Age of Teen:

Family's response to this event:

Medication:

Please describe any medications that address mental health related issues:

Name of medication	Effective?	Currently taking it?
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Yes ☐ No	☐ Yes ☐ No

Early Development:

Were there any complications during pregnancy? ☐ Yes ☐ No If yes, please explain:

Did mother take medication during pregnancy? ☐ Yes ☐ No If yes, please explain:

Did mother use drugs/alcohol during pregnancy? ☐ Yes ☐ No If yes, please explain:

Were there complications during birth? ☐ Yes ☐ No If yes, please explain:

Was the pregnancy full term? ☐ Yes ☐ No If yes, please explain:

In teen's first year of life, did he/she experience:

Colic? ☐ Yes ☐ No Feeding problems? ☐ Yes ☐ No Sleeping problems? ☐ Yes ☐ No

Did he/she meet developmental milestones (walking, talking, crawling) on time? ☐ Yes ☐ No

Please describe the teen as a baby:

Social and School Functioning:

Please describe how you (the teen) interact with peers and other teens (please include siblings):

What do you (teen) like to do with friends?

How much time is spent watching television/playing videogames/using the computer daily?

Are you (the teen) having any challenges at school (suspension, failing, truancy, trouble with teachers, etc.)?

Please describe your (teen's) academic performance (grades):

Have you (teen) ever been diagnosed with a learning disability/problem? ☐ Yes ☐ No If yes, please explain:

Do you (teen) use special education services (have an IEP)? ☐ Yes ☐ No If yes, please explain:

Symptoms:

Please make a check mark to indicate that you (teen) are experiencing this symptom then indicate on a scale from 1-5 how severe the symptom is. 1 notes that you experience this symptom very infrequently and that the symptom is minimally disruptive. 5 notes that you experience this symptom frequently and it is extremely disruptive.

Sadness/Mood: *How often do you experience the following:*

	Rarely		Sometimes		Always
• Appearing mopey and sad	1	2	3	4	5
• Irritability	1	2	3	4	5
• Withdrawing from others	1	2	3	4	5
• Decreased enjoyment in activities	1	2	3	4	5
• Change in sleep pattern	1	2	3	4	5
• Low self-esteem	1	2	3	4	5
• Weight loss/gain	1	2	3	4	5
• Excessive tantrums/rages	1	2	3	4	5
• Emotions that change quickly	1	2	3	4	5

Anxiety: *How often do you experience the following:*

	Rarely		Sometimes		Always
• Worried or anxious	1	2	3	4	5
• Obsessive or compulsive	1	2	3	4	5
• Stomachache/headache	1	2	3	4	5
• Restlessness	1	2	3	4	5

• Nightmares	1	2	3	4	5
• Witnessed traumatic event	1	2	3	4	5
• Trouble concentrating	1	2	3	4	5
• Trouble falling asleep	1	2	3	4	5

Defiance/Misc. Behavior: *How often do you experience the following:*

	Rarely				Always
• Defies adult requests	1	2	3	4	5
• Aggressive towards people/animals	1	2	3	4	5
• Stealing	1	2	3	4	5
• Lying	1	2	3	4	5
• Destroys property	1	2	3	4	5
• Sexuallly acting out	1	2	3	4	5
• Fire setting	1	2	3	4	5
• Argues with adults	1	2	3	4	5
• Running away from home	1	2	3	4	5
• Threatens self harm/harm to others	1	2	3	4	5
• Cutting	1	2	3	4	5

ADHD: *How often do you experience the following:*

	Rarely				Always
Difficulty paying attention	1	2	3	4	5
Poor concentration	1	2	3	4	5
Has difficulty organizing homework	1	2	3	4	5
Poor impulse control	1	2	3	4	5
Fidgets	1	2	3	4	5

Are there any additional behaviors/symptoms you have concerns about? If so, please explain:

Strengths and Spirituality:

Please tell me about the things you (teen) are good at/proud of:

(Caregiver/parent) Describe your teen's best qualities:

What gives you (teen) strength during challenging times?

Do you or your family have a religious affiliation, spiritual belief system or way of life that would be helpful for me to know about?

What are your (teen's) hobbies, extracurricular activities or interests?

Is there anything else that is important for me to better understand your current challenges and work with your family?

Thank you for your assistance in completing this assessment.