

ADOLESCENT CLIENT INTAKE FORM

To be completed by the client

BACKGROUND INFORMATION

DATE _____

Your Name: _____ DOB: _____ Gender: _____

Home Address: _____

Email Address: _____ May I send a message here? Yes No

Home Phone: (____) _____ May I leave a message here? Yes No

Cell Phone: (____) _____ May I leave a message here? Yes No

Grade in School: _____ What school do you go to? _____

SOCIAL SUPPORTS

Do you have friends in your life that you trust? Yes No

If yes, who: _____

Do you have adults in your life that you trust (not including parents)? Yes No

If yes, who: _____

Are you having any problems or issues in school? Yes No

If yes, describe: _____

Are you part of any teams, groups, or other activities? Yes No

If yes, describe: _____

Do you regularly attend a place of worship? Yes No

If yes, where: _____

Would you like your spiritual/religious beliefs to be included in your counseling? Yes No

What are some of your interests, hobbies, and things that you do for fun? _____

MEDICAL AND HEALTH ISSUES

Do you have any physical health problems that cause you pain or distress? Yes No

If yes, describe: _____

Are you sexually active? Yes No Are you confused about your sexual orientation? Yes No

Have you used alcohol in the past six months? Yes No How often? _____

Have you used illegal drugs? Yes No If yes, which drugs? _____

Do you have a primary care doctor who you feel comfortable with? Yes No

What is your doctor's name? _____

PRESENTING ISSUES

In your own words, tell me why you are coming to counseling: _____

Please circle any issue that has distressed, worried, or bothered you in the past 3 months:

- | | | |
|----------------------------------|--------------------------|-------------------------------|
| Feeling angry | Feeling timid or shy | Feeling depressed |
| Being easily embarrassed | Feeling like a failure | Feeling on the verge of tears |
| Uncomfortable around others | Feeling discouraged | Not feeling like eating |
| A lack of friends | Feeling shy around peers | Blame or criticize others |
| Difficulty holding conversations | Feeling hopeless | Headaches |
| Difficulty with sleep | Stay by yourself a lot | Feeling tense and nervous |
| Upset stomach | Problems with family | Upset by academic concerns |
| Stress related to school | Feeling overweight | Problems with anxiety |
| Unhappy with family | Poor self esteem | Unwanted sexual experiences |
| Experienced physical abuse | Difficulty focusing | Experienced emotional abuse |

Other issues not listed here: _____

Are you currently experiencing any suicidal thoughts? Yes No

Have you experienced them in the past? Yes No

Have you ever attempted suicide? Yes No

If yes, when and how: _____

Have you had any previous psychiatric hospitalizations? Yes No

If yes, when and where: _____

Have any of your friends or family ever attempted or completed suicide? Yes No

If yes, when and who: _____

Is there anything else that I should know about you or your life right now? _____

TERMS OF SERVICE

I certify that the above information is complete and truthful to the best of my current knowledge and ability. I understand that my personal information is kept confidential, unless an exception is made according to the Notice of Privacy Practices, which I have received.

Client Name (Please Print) _____

Client Signature _____ Date _____