Cassie Salewske, MA LMHC NCC CHt
Healing Tree Counseling and Wellness, LLC
1812 E. Madison Street, Suite 102, Seattle WA 98122
www.healingtreeseattle.com
206-595-8621

ADOLESCENT CLIENT INTAKE FORM

To be completed by the client

BACKGROUND INFORMATION

Your Name: _____ DOB: _____ Gender: _____

Name you prefer: _____ Pronoun Preference: _____

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 If yes, 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/worry
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: _____

Are you currently self-harming (cutting, burning, hitting yourself)? Yes No

Have you self-harmed in the past? 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 _____