Intake Form for Parent & Adolescent

This intake form requires information on BOTH parent and adolescent. Please read each section carefully to understand which section pertains to you and which section pertains to your adolescent

CUSTODIAL PARENT/GUARDIAN INFORMATION (who has legal custody of this adolescent?)

_____ Both Parents _____ Mother _____ Father
_____ Other (*complete information below*)

First Name: _____ cell phone: _____

Last Name: _____ work phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB: _____ ____ Male ____ Female SSN: _____ / _____ / _____

Relationship to adolescent: _____

PARENT INFORMATION

Mother

First Name: _____ cell phone: _____

Last Name: _____ work phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB (mm/dd/yyyy): _____ / _____ / _____ SSN: _____ / _____ / _____

Occupation: _____ How Long? _____

Place of Employment: _____

Highest level of education: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed ___ Cohabitating

If married: wedding date: _____ / _____ / _____ How many previous marriages? _____

If spouse is step-parent or if you are cohabitating:

Name: _____
Get along with client? ____ Yes ____ No

Father

First Name: _____ cell phone: _____

Last Name: _____ work phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

DOB (mm/dd/yyyy): _____ / _____ / _____ SSN: _____ / _____ / _____

Occupation: _____ How Long? _____

Place of Employment: _____

Highest level of education: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed ___ Cohabitating

If married: wedding date: _____ / _____ / _____ How many previous marriages? _____

If spouse is step-parent or if you are cohabitating:

Name: _____
Get along with client? ____ Yes ____ No

ADOLESCENT/CLIENT INFORMATION

First Name: _____ Last Name: _____

Preferred Name (if different from above): _____

DOB (mm/dd/yyyy): _____ / _____ / _____ SSN: _____ / _____ / _____

School: _____ Grade: _____

Physician(s): _____

Adolescent's Medications

Medication	Dosage	Frequency

Past Medications

Medication	Dosage	Frequency

List all the persons living in the home with the adolescent

Name	Age	Sex	Relation to client

Other siblings not in the home

Name	Age	Sex	Relation to client

Is there anything causing your family stress right now? ____ Yes ____ No

If “yes,” please explain: _____

_____

Is this teen at risk for out of home placement because of behavior problems? ___ Yes ___ No

If “yes,” please explain: _____

_____

Has this teen been subject to abuse (physical, sexual, emotional, or neglect)? ___ Yes ___ No

If “yes,” what form(s) of abuse: _____

What are your teen's assets or strengths? _____

_____

_____

What have you found to be satisfactory ways to help your teen? _____

_____

_____

How were you referred to Ministry of Counseling? _____

Have you sought counseling for this teen in the past? ___ Yes ___ No

If "yes," Where and when? _____

CHECK LIST

Check any of the following behaviors that are currently true of your teen

- ☐ Affectionate
- ☐ Angry
- ☐ Argues, "talks back," smart-alecky, defiant
- ☐ Blames others for his/her actions
- ☐ Bored
- ☐ Bullies/intimidates, teases, inflicts pain on others
- ☐ Bossy to others, picks on, provokes
- ☐ Cheats
- ☐ Clings to you too much
- ☐ Cruel to animals
- ☐ Concerned for the well-being of others
- ☐ Conflicts with parent(s) over chores, money, persistent rule breaking, friends, school
- ☐ Confused
- ☐ Cries easily, feelings are easily hurt
- ☐ Dawdles, procrastinates, wastes time
- ☐ Difficulty with parent's new marriage/new family
- ☐ Dependent/immature
- ☐ Developmental delays
- ☐ Disrupts family activities
- ☐ Disobedient, uncooperative, refuses, non-compliant, doesn't follow rules
- ☐ Distractible, inattentive, poor concentration, daydreams, slow to respond

- [ ] Dropping out of school
- [ ] Drug or alcohol abuse
- [ ] Eating (poor manners, refuses, appetite increase or decrease, odd combinations, overeats)
- [ ] Exercise problems
- [ ] Extracurricular activities interfere with academics
- [ ] Failure in school
- [ ] Fearful
- [ ] Fighting, hitting, violent, aggressive, hostile, threatens, destructive
- [ ] Fire setting
- [ ] Friendly, outgoing, social
- [ ] Guilty
- [ ] Hard time making and keeping friends
- [ ] Headaches
- [ ] Hypochondriac, always complains of feeling sick
- [ ] Immature “clowns around,” has only younger playmates
- [ ] Imaginary playmates
- [ ] Independent
- [ ] Interrupts, talks out, yells
- [ ] Lacks organization, unprepared
- [ ] Lacks interest in things he/she used to like
- [ ] Lacks remorse
- [ ] Lacks respect for authority, insults, dares, provokes, manipulates
- [ ] Learning disability
- [ ] Legal difficulties: truancy, loitering, panhandling, vandalism, stealing, fighting, drug sales
- [ ] Likes to be alone, withdraws, isolates
- [ ] Lying
- [ ] Low frustration tolerance, irritability
- [ ] Moody
- [ ] Mute, refuses to speak
- [ ] Nail biting
- [ ] Nervous
- [ ] Nightmares
- [ ] Need for high degree of supervision at home
- [ ] Obedient
- [ ] Obesity
- [ ] Overactive, restless, hyperactive, out-of-seat behaviors, fidgety, noisiness
- [ ] Prejudiced, bigoted, insulting, name-calling, intolerant
- [ ] Pouts
- [ ] Recent move, new school, loss of friends
- [ ] Relationship with siblings and/or peers are poor
- [ ] Responsible
- [ ] Runs away from home
- [ ] Sad, unhappy

- ☐ School problems
- ☐ Sees or hears things that aren't there
- ☐ Self-harming behaviors (biting, hitting, cutting self, hair pulling, scratching)
- ☐ Shy, timid
- ☐ Sleeping trouble: too much or too little
- ☐ Stomach aches
- ☐ Strange thoughts
- ☐ Stubborn
- ☐ Suicide talk or attempt
- ☐ Swearing, foul language
- ☐ Temper tantrums, rages
- ☐ Thumb sucking, finger sucking, hair chewing
- ☐ Tics (involuntary rapid movements, noises, or word productions)
- ☐ Teased, picked on, victimized, bullied
- ☐ Under active (slow moving, lethargic)
- ☐ Uncoordinated, accident-prone
- ☐ Vomits often
- ☐ Wetting or soiling the bed or clothes
- ☐ Will not eat
- ☐ Work problems (can't keep a job, or works too much); difficulty with co-workers

COMMENTS
(Please write anything else you want us to be aware of in the space below)

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THE FOLLOWING PAGES: "Adolescent Confidential Questionnaire"
are to be completed by adolescent
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Adolescent Confidential Questionnaire

Please fill out the following questions about yourself as completely as possible by writing, checking, or circling the correct answer.

General Information

First Name: _____ Last Name: _____

Preferred Name (if different from above): _____

Date of Birth: _____ /_____ / _____ Cell Phone: _____

Preferred Pronouns (circle applicable): Him/he/his She/her/hers
They/them/their
Other: _____

Whose idea was it for you to come to counseling?

_____ Mine _____ Parent(s) _____ other (who?) _____

What is your opinion about being here?

_____ It's fine with me
_____ I don't care either way
_____ I'm against it

Family Information

List all the people living in the home with you (excluding yourself)

Name	Age	Sex	Relationship

family info. continued...

Describe your relationship with your father:

Describe your relationship with your mother:

If you have brothers or sisters, describe your relationship with them:

If you have step-parents, describe your relationship with them:

What relative (not including your parents, brothers, or sisters) are you closest?

Why are you closest to this relative?

Social Information

Where do you attend school? _____ Grade: _____

What activities (if any) are you involved with at school?

What do you like about school?

What do you dislike about school?

Social info continued...

How much time do you spend with friends?

_____ a lot _____ some _____ not much

List the first names of 3 of your closest friends:

1. _____
2. _____
3. _____

Do you have a boyfriend or girlfriend? _____ Yes _____ No

If “yes”, how long have you been dating? _____

What do you do for fun?

What kind of music do you listen to the most? _____

What other kinds of music do you like?

Who are 3 of your favorite artists/groups?

1. _____
2. _____
3. _____

Do you attend church? _____ Yes _____ No

If “yes”, what is the name of your church? _____

Health Information

How would you rate your overall health? _____ excellent _____ good

_____ fair _____ poor

Have you recently had any significant weight gain or loss?

_____ Yes weight gain _____ Yes weight loss _____ Nothing significant

If “yes” to either, approximately how much weight? _____

Personal Information

Check all the feelings you often have:

____ happy	____ irritable	____ confused	____ hyper/energetic
____ worried	____ sad	____ anxious	____ confident
____ guilty	____ lonely	____ angry	____ bored
____ shy	____ depressed	____ worthless	____ hopeless

____ others?: _____

Check all the FEARS you have had in the past 3 months:

____ Dark	____ New situations	____ Being alone
____ Death	____ Visiting a friend's house	____ Animals
____ Separation from a parent	____ Spending the night from home	

____ others?: _____

List any major changes in your life over the last 5 years:

Briefly describe what is happening in your life that brings you to counseling:

How long has this been a problem?

If there is any other information you believe would be helpful for the therapist to know, please use the space below to provide it (use the back of this page if necessary).