Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (ages 12-17)

__Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-8

CLIENT INFORMATION

Name:_____**Date of Birth**:_____
Age: _____
Phone (Cell): _____**Messages okay**?_____
Text Reminder okay?_____
School_____
Grade:_____
Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:
_____
Do your parents have access to your electronic communication? (Y/N)
Do they have any issues with your use of phone, text, electronic communication? (Y/N)

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?
_____
_____
_____
_____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)
_____
_____
_____
_____
_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for?
_____
_____
_____
_____

What would you like to see happen as a result of counseling?
_____
_____
_____
_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor?_____ If yes, what did you find most helpful in therapy?

_____
_____
_____

If yes, what did you find least helpful in therapy?

_____
_____
_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes, _____No
If yes, how often do you drink? _____Daily_____Weekly_____Occasionally _____Rarely_____
If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? _____Yes_____No
If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes_____No
I**f yes, what drugs do you use?**

_____
_____
_____

If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely____

Have you received any previous treatment for chemical use? Y/N _____
If so, where did you go?_____

____**Inpatient** _____**Outpatient**

Adolescents (please answer the following with Y/N)
Have you ever used more than 1 chemical at the same time to get high? _____
Do you avoid family activities so you can use? _____
Do you have a group of friends who also use? _____
Do you use to improve your emotions such as when you feel sad or depressed?_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the
past._____
_____
_____

FAMILY HISTORY

Are your parents married or divorced? _____
Do you think their relationship is good? (Y/N/Unsure)_____
If your parents are divorced, whom do you primarily live with?
_____
How often do you see each parent? Mom_____% Dad _____%.

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? _____

Please describe as much as you feel comfortable.
_____
_____
_____
_____

FAMILY CONCERNS
(Please check any family concerns that your family is currently experiencing)

Symptoms	Describe
Arguing with Siblings	
Disagreeing with Parents/Grandparents	
Feeling Distant	
Loss of Fun	
Alcohol Use	
Lack of Honesty	
Drug Use	
Physical Fights	
Education Problems	
Divorce/Separation	
Financial Problems	
Issues Regarding Remarriage	
Death of Family Member	
Birth of Sibling	
Abuse or Neglect	
Disagreeing with Friends	

Other concerns not listed above _____
_____

PEER RELATIONS

How do you consider yourself socially:
___outgoing ____shy ____depends on the situation

Are you happy with the amount of friends you have? (Y/N)_____

Have you ever been bullied? (Y/N) _____If Yes When?_____

Are your parents happy with your friends? (Y/N)_____

Are involved in any organized social activities (e.g. sports, scouts, music)?
_____
_____
_____

SCHOOL HISTORY

Do you like school? (Y/N)_____ Favorite Subject:_____Worse Subject:_____
Do you attend regularly? (Y/N)_____
What are your current grades? _____
Do you feel you are doing the best you can at School? (Y/N) _____
Is it hard for you to pay attention? Y/N_____Is it hard to get Organized? _____

INDIVIDUAL CONCERNS

	None	Mild	Moderate	Severe
Appetite Changes				
Poor Concentration				
Low Self Worth				
Irritability				
Anger Issues				
Nausea/ Indigestion				
Social Anxiety				
Hallucinations				
Self Mutilation				

	None	Mild	Moderate	Severe
Racing Thoughts				
Spiritual Concerns				
Hyperactivity				
Low Energy				
Lonliness				
Excessive worry				
Unresolved Guilt				
Indecisveness				
Cutting				
Restlessness				
Impulsivity				
headaches				
Weight changes (unplanned)				
Alcohol Use				
Easily Distracted				
Drug Use				
Binging/Purging				
Nightmares				
Hoplessness				
Elevated Mood				
Suicidal Thoughts				
Past Suicide Attemps				
Mood Swings				
Trauma				
Flashbacks				
Obsessive Thoughts				

	None	Mild	Moderate	Severe
Panic Attacks				
Feeling Anxious				
Feeling Panicky				
Disorganized				
Anorexia				
Grief				
Sadness				
Crying				
Social Isolation				
Sleep Disturbances				
Paranoid Thoughts				
Problems at Home				

List any Phobias /Fears?

_____

_____

SUICIDAL THOUGHTS / PAST SUICIDE ATTEMPTS OTHER

_____

_____

_____

_____

Thank you for taking the time to fill out this detailed questionaire.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Please fill out forms as completely as possible and have them ready before your first counseling session.

Adolescent"s Name_____Date:_____

Date of Birth: _____ Age: _____
Race/Ethnic Origin:_____ Religious Preference:_____
Adolescent Identify's: Male_____Female_____Transgendered_____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name:_____

Relationship (Biological, Adoptive, Step Parent)_____

Age:_____Adolescent Living with you? Y/N_____

PARENT'S MARITAL STATUS

(this question refers to the biological parents relationship)

Single_____ Married _____ Divorced_____ Cohabitating_____
Divorce in process _____ Separated _____Widowed _____
Other _____

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

Please answer the following as best as you can, I understand that you may not be able to answer some of the questions pertaining to the other parent

Biological Father's Name: _____
Birth Date:_____ Age:_____
EthnicOrigin:_____
Total years of education completed: _____ Occupation: _____
Place of Employment:
_____
Military experience? Y/N _____ Combat experience? Y/N _____

If Divorced Please list your Ex-spouses Current Status
_____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

Assessment of youir current relationship with Bio-Mother if applicable:
Poor_____ Fair_____ Good_____

Biological Mother's Name: _____
Birth Date:_____ **Age:** _____
EthnicOrigin:_____
Total years of education completed: _____ **Occupation:** _____ _____
Place of Employment:
_____
Military experience? Y/N _____ **Combat experience? Y/N** _____

If Divorced Please List your Ex-spouses Current Status
_____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

Assessment of youir current relationship with Bio-Father if applicable:
Poor_____ Fair_____ Good_____

Parenting Arrangement if Divorced: (Please Check Days & List Times)

Shared Parenting Time	Mom	Dad
Monday (Time)		
Tuesday (Time)		
Wednesday (Time)		
Thursday (Time)		
Friday (Time)		
Saturday (Time)		
Sunday (Time)		

Please list how medica/psychiatricl decisions are made as stated in Divorce Joint Parenting Agreement (feel free to attach copy of that agreement)
_____
_____
_____
_____

Assessment of current relationship with biological parent
Poor_____ Fair_____ Good_____

How would you determine the current state of your relationship with your Ex-Spouse in regards to Co-Parenting? (check all that apply-explain if you would like)

Amicable	
Similiar parenting strategies	
Hostile	
No communication face to face	
Shared Activities	
In and out of court system	
Friends	
email only communication	

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____
_____
_____
_____
_____
_____

What would you like to see happen as a result of counseling?

_____
_____
_____

What is most concerning right now?

_____
_____
_____
_____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?
Yes ___ No ___ If yes, describe:

_____
_____

Did your child have health problems at birth? Yes _____ No _____
If yes, describe:

_____
_____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
Yes ___ No ___ Not sure_____
If yes, describe:

_____
_____

Did your child ever receive Occupational Therapy Services? Yes____No____Not Sure_____
If Yes Describe:

_____
_____

Did your child have any unusual behaviors or problems prior to age 3?
Yes ___ No ___Not sure_____
If yes, describe:

_____
_____
_____

Has your child experienced emotional, physical, or sexual abuse?
Yes ____ No ____ Not sure _____ If yes, describe:

_____
_____

COUNSELING HISTORY

Has your son or daughter previously seen a counselor Yes_____No_____
If Yes, where:

_____

Approximate Dates of Counseling:

_____

For what reason did your son or daughter go to counseling?

_____

Does your son or daughter have a previous mental health diagnosis? If so please list

_____

What did you find most helpful in therapy for your child?

_____
_____
_____

What did you find least helpful in therapy?

_____
_____
_____

Has your son or daughter used psychiatric services (psychiatrist) ? Yes____ No____
If yes, who did they see?

_____

If yes, was it helpful? N/A____ Yes____ No_____
Name of Medication:_____
Dates Taken:_____

Has your son or daughter taken medication for a mental health concern? Yes___No ____
If Yes Describe:_____

Does your son or daughter have other medical concerns or previous hospitalizations? Yes/ No If so, please describe._____

_____
_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? Yes__No__
If yes, please explain your concern:

_____
_____
_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? Yes ___No____
If yes, please explain your concern:

_____
_____
_____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____
_____
_____

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3?

_____
_____
_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____
_____
_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? _____

_____
_____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

Fighting	
Disagreeing about Relatives	
Feeling Distant	
Disagreeing about friends	
Alcohol Use	
Lack of Honesty	
Drug Use	
Physical Fights	
infidelity (couple)	
Education Problems	
Divorce/Separation	
Financial Problems	
Issues Regarding Remarriage	
Loss of fun	

Death of a Family Member	
Birth of a Sibling	
Abuse/Neglect	
Birth of a child	
Inadequate Housing	
Feeling Unsafe	
Inadequate Health Insurance	
Job Change	
Job Dissatisfaction	
Other	

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____
_____
_____

What are 5 Personality Traits that you would use to describe your son or daughter ?

1._____
2._____
3._____
4._____
5._____

How would your son or daughter describe themselves?

1._____
2._____
3._____
4._____
5._____

Who are some of the influential and supportive people in your son or daughters life?

_____
_____
_____
_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

	None	Mild	Moderate	Severe
Sadness				
Appetite Changes				
Crying				
Weight Changes (unplanned)				
Sleep Disturbances				
Paronoid Thoughts				
Dissociation				
Poor Concentration				
Hyperactivity				
Indecisiveness				
Binging/Purging				
Low Energy				
Excessive Worry				
UNresolved Guilt				
Low Self Worth				
Irritability				
Anger Issues				
Spiritual Concerns				
Nausea/ Indegestion				
Social Anxiety				
Hallucinations				
Self Mutalation				
Racing Thoughts				

	None	Mild	Moderate	Severe
Cutting				
Restlessness				
Impulsivity				
Drug Use				
Nightmares				
Alcohol Use				
Decreased Creativity				
Easily Distracted				
Trauma Flashbacks				
Work Issues				
Problems at Home				
Panaic Attacks				
Feeling Anxious				
Feeling Panicky				
Suicidal Thoughts				
Past Suicide Attempts				
Hopelessness				
Elevated Mood				
Mood Swings				
Disorganized				
Anorexia				
Social Isolation				
Phobias				
Obsessive Thoughts				
Grief				

	None	Mild	Moderate	Severe
Headaches				
Lonliness				

Is there anything else you would like to share:

_____
_____
_____
_____
_____
_____
_____

Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with this therapist. This means that some of the issues that they discuss will not be disclosed, and that I will not disclose that information to anyone, including you, unless I have been given permission by your child to do so. I need your child to be open and honest with me in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. I also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why I will always encourage your child to be honest with you. I will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to the State of Illinois Confidentiality Act and the federal patient privacy law known as HIPAA, your child (12+) will need to give his/her consent for us to disclose:
• All Mental Health records for children age 12 or older.
• All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
• Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.
• You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.
• In addition, there are situations that I am mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.
• Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.