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CONFIDENTIAL ADOLESCENT INTAKE FORM

Name: _____ Date: _____
Parent's Name: _____
Okay to send US mail? Yes □ No □
Address: _____
D.O.B./Age/Ethnicity: _____

	Okay to call?	Okay to leave message?
Home Phone: _____	Yes □ No □	Yes □ No □
Cell Phone: _____	Yes □ No □	Yes □ No □
Parent's Cell Phone: _____	Yes □ No □	Yes □ No □

Okay to email?
Email: _____ Yes □ No □
Okay to text?
Text Message: _____ Yes □ No □
In case of an emergency, please provide a name and number:
_____

DEMOGRAPHIC INFORMATION

Status of Parent's Relationship: □ Single □ Married □ Separated □ Divorced □ Widowed

REFERRAL INFORMATION

Who referred you to me or how did you hear of my practice? _____
Current reason(s) for seeking therapy:
_____
_____
Estimate the severity of the issue for which you are seeking care: □ Mild □ Moderate □ Severe □ Very Severe

PAST TREATMENT: PSYCHOLOGICAL, BEHAVIORAL OR EMOTIONAL DIFFICULTIES

What do you hope to accomplish through counseling?
_____
_____
_____

Inpatient Hospital Treatment (hospital, date, reason, length of stay):
_____
_____

Previous Therapy (therapist's name, date, reason, outcome):
_____
_____
Was it helpful? Why or why not? _____

Current Medications (If more room is needed, please use the back of this form):
Name Dosage: _____ Purpose: _____
Name Dosage: _____ Purpose: _____
Who prescribes them? _____
May I request and release information to/from this prescriber? □ Yes □ No Phone Number:
_____

RELEVANT MEDICAL HISTORY

Date of last physical exam: _____
Are you being treated for any medical problems? □ Yes No If yes, what? _____
Current primary care provider: _____ Phone number: _____
Have you ever sustained a serious head injury? □ Yes □ No
If so, please indicate how/when:
_____
Are you taking any other prescription drugs other than those already noted? □ Yes □ No
If yes, Name of drug: _____Dosage: _____
Purpose: _____
Name of drug: _____Dosage: _____
Purpose: _____

SUBSTANCE USE/ABUSE HISTORY

In the past 3 months have you used any intoxicants? □ Yes □ No
If yes, please identify what type (i.e., alcohol, pot, cocaine) and how much:
_____
How often: _____
Have you ever been treated for substance abuse or attended AA/NA? □ Yes □ No
Have you ever tried to stop or reduce your use on your own? □ Yes □ No
Has it ever affected your work or your relationships? □ Yes □ No

FAITH INVOLVEMENT

Do you attend a regular worship services? □ Yes □ No
How important is your faith to you on a scale of 1 to 10 (10 being the highest): _____

EDUCATION

Where do you attend school and what grade are you in? _____
Were you ever diagnosed with a learning disability? □ Yes □ No
If yes, what was it?: _____

DOES YOUR FAMILY HAVE A HISTORY OF ANY OF THE FOLLOWING

□ Depression □ Anxiety □ Panic Attacks □ Eating Disorders □ Abuse □ Bipolar Disorder □ Alcohol/drug use
□ Schizophrenia □ Attempted or completed suicide □ Other mental health concerns (_____)

_____Please note and initial. Payment for services are due at the beginning of each session, unless other arrangements have been made.
_____ Please note and initial: If you are unable to keep your appointment, please give 48 hours notice or you will be charged for the time reserved. Thank you!