ADOLESCENT INTAKE FORM

Name: ____ ☐ Male ☐ Female ☐ Other

Date of Birth: mm/dd/yyyy ______________ Age: ____ Current school grade level: _____

Parent/Legal Guardian Information

Name: ____ Date: _______________________

Address: _______________________________ City: ______________ State: ___ Zip: ______

Phone: ________________________ (☐ Home ☐ Work ☐ Cell) OK to leave message? ☐ Yes ☐ No

Daytime Phone: _________________ (☐ Home ☐ Work ☐ Cell) OK to leave message? ☐ Yes ☐ No

Alternate Phone: ________________ (☐ Home ☐ Work ☐ Cell) OK to leave message? ☐ Yes ☐ No

Date of Birth: mm/dd/yyyy _____________ Age: ______

Please list everyone who currently lives in the adolescents' household

Name	Age	Gender	Living w/ you?	Relationship To You
		M F	Y N	
		M F	Y N	
		M F	Y N	
		M F	Y N	

If client is under 18 years old:

Father's name: ____

Mother's name: ____

Parental Status: *Single Engaged Living Together Married Separated Divorced Widowed*

Custodial Parent: *Joint Custody, Sole Custody, Legal Guardian*

Who should be notified in case of emergency?

Name: ______________________________ Relationship: ______________________________

Phone: _________________________ (□ Home □ Work □ Cell) OK to leave message? □ Yes □ No

Alternate Phone: _________________ (□ Home □ Work □ Cell) OK to leave message? □ Yes □ No

Please list current medications including prescription and over the counter medications				
Medication	*Dosage*	*Began MM/YY*	*For what Symptom(s)*	*Prescribing Doctor*

Current Concerns in Entering Therapy: ****Please List Distress Level: 1 some, 2 Moderate, 3 Quite a bit, 4 Extreme***		
Concern	*Length of Time*	**Distress Level*

Current Physician(s) Monitoring Adolescent Care		
Name of Physician	*Specialization*	*Length of Time*

Please provide the following information
(circle all that apply)

Gender Identity
- Male
- Female
- Other

Sexual Orientation
- Heterosexual
- Gay/Lesbian
- Bisexual

Religious Affiliation
- Catholic
- Protestant
- Mormon
- Jewish
- Other
- None

Current Level of Education

- Elementary School
- Junior High School
- High School (or GED)

Ethnic or Racial Origin
- American Indian/ Alaska Native
- Asian
- African American/Black
- Caucasian/White
- Mexican-American/Hispanic
- Biracial
- Other: ________________________

How Did You Learn About Me?

Former Client
Friend/Family Member
Hospital/Physician
Another Professional
Internet Site
Name: ________________________
Other: ________________________

Please indicate problems that are a concern:
(*circle all that apply*)

chronic illness/pain:
depression
anxiety/Worries
stress
sexual abuse
eating disorder
relationship problem
physical problem
excessive alcohol/drugs
gender identity
family relationships
sexual problems
self-esteem
suicidal thoughts
anger
grief
self-injury 'self-mutilation
emotional abuse
physical abuse

other (please specify) ______________________________

How often do you drink alcohol?
Never
Less than once a month
About once a week
2 to 3 days a week
4 to 6 days a week
Daily

How often do you use drugs?
Never
Less than once a week
About once a week
2 to 3 days a week
4 to 6 days a week
Daily

Do you drink now more than in the past?
Yes: _____ No: _____

Do you use drugs more often than the past?
Yes: _____ No: _____

Has anyone objected to your drinking?
Yes: _____ N: _____

Has anyone objected to your drug use?
Yes: _____ No: _____

When was the last time you drank alcohol or used drugs? ____________________________

How often do you use tobacco products?
Never
Less than once a month
About once a week
2 to 3 days a week
4 to 6 days a week
Daily

Do you use tobacco products more than in the past?
Yes: _____ No: _____

Has anyone objected to your tobacco use?
Yes: _____ No: _____

I understand the information provided to be true and accurate.

Signature of Parent and/or Guardian Date