Adolescent Intake Form

Name: ______________________________ DOB: ____________ Date: ______________

Presenting Problems and Concerns

Describe the problem(s) that brought you to see me:__________________________________

____

What are your goals in therapy?____

____

Please check all your child's behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Sadness/depression
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Fatigue
- ☐ Recurring disturbing memories
- ☐ Changes in appetite
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Phobias
- ☐ Obsessive thoughts
- ☐ Compulsive Behavior
- ☐ Racing thoughts
- ☐ Wide mood swings
- ☐ Suspicion/paranoia
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Defiance
- ☐ Aggression/fights
- ☐ Homicidal thoughts
- ☐ Frequent arguments
- ☐ Arability/anger
- ☐ Peer/sibling conflict
- ☐ Stealing
- ☐ Destroying property
- ☐ Running away
- ☐ Swearing
- ☐ Curfew violations
- ☐ Lying
- ☐ Other:_______________
- ☐ Manipulative behavior
- ☐ No/few friends
- ☐ Eating problems
- ☐ Sleeping problems
- ☐ Nightmares
- ☐ Toileting problems
- ☐ Fire setting
- ☐ Work/school problems
- ☐ Legal problems
- ☐ Sexual behavior
- ☐ Computer addiction
- ☐ Alcohol/drug use
- ☐ Lack of motivation

Are your child's problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Work/school
- ☐ Relationships
- ☐ Housing
- ☐ Hygiene
- ☐ Legal matters
- ☐ Health
- ☐ Finances

Has your child ever had thoughts, made statements, or attempted to hurt him/herself? ☐ Yes ☐ No

If yes, please explain:____

____

Has your child ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes ☐ No

If yes, please explain:____

____

Has your child recently been physically hurt or threatened by someone else? ☐ Yes ☐ No

If yes, please explain:____

____

Has your child gambled in the past 6 months? ☐ Yes ☐ No ☐ NA If yes please answer the following.

Has your child felt the need to bet more and more money? ☐ Yes ☐ No

Has your child ever had to lie to people about how much he/she has gambled ☐ Yes ☐ No

Family and Development History

Relationship	Name	Living with Child	Age	Quality of Relationship
Mother				
Father				
Step-Mother				
Step-Father				
Siblings				
Other Relatives				

Family Mental Health History	Who?
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive-Compulsive	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated
☐ Mother remarried: Number of times ____________
☐ Father remarried: Number of times ____________

Please check if your child has experienced any of the following types of trauma or loss:

☐ Emotional Abuse
☐ Sexual Abuse
☐ Physical Abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

Were there any medical problems during the pregnancy or birth of your child? ☐ Yes ☐ No

If yes, please explain:____

____

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child?

☐ Yes ☐ No If yes, please describe the substances used, quantity and frequency:_________________

____

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)

☐ Yes ☐ No If yes, please describe:____

____

Previous Mental Health Treatment

Yes	No	Type of Treatment	When	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Self-help/support groups			

School Information

Current grade/placement:____________

This year's school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Past school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
This year's school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Past school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Has your child had any of the following difficulties at school?

☐ Suspension ☐ Incomplete homework ☐ Learning problems ☐ Referrals
☐ Poor grades ☐ Teased/picked on ☐ Speech problems ☐ Attendance problems
☐ Gang influence

Does your child have an after-school care provider? ☐ Yes ☐ No If so, who?__________________________

Has your child ever repeated or skipped a grade? ☐ Yes ☐ No If so, which ones?____________________

Has your child ever received special education services? ☐ Yes ☐ No If so, please describe services received and reason for services:____

Substance Use History (for ages 12 and older if applicable)

Substance Type	Current Use				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Meth								
Pain Killers								
PCP/LSD								
Steroids								
Tranquilizers								

Has your child had withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No

Please describe:____

____

Has your child ever had problems with work, relationships, health, the law, etc. due to his/her substance use?

☐ Yes ☐ No If yes, please describe:____

____

Medical Information

Date of last physical examination:_________________________

Has your child experienced any or the following medical conditions during his/her lifetime?

☐ Allergies ☐ Asthma ☐ Headaches ☐ Stomach aches
☐ Chronic Pain ☐ Surgery ☐ Serious accident ☐ Head injury
☐ Dizziness/fainting ☐ Meningitis ☐ Seizures ☐ Vision problems
☐ High fevers ☐ Diabetes ☐ Hearing problems ☐ Ear infections
☐ Miscarriage ☐ Abortion ☐ Sleep disorder ☐ Sexually transmitted disease
☐ Other: ____

Please list any CURRENT health concerns:____

Current prescription medications: ☐None

Medication	Dosage	Date first Prescribed	Prescribed by

Current over-the-counter medications (including vitamins, herbal remedies, etc.):_______________________

____

Allergies and/or adverse reactions to medications:____

____

Interpersonal/Social/Cultural Information

Please describe your child's social support network (check all that apply):

☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-Workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one?________________________________)

To which cultural or ethnic group does your child belong?_____________________________________

If your child is experiencing any difficulties due to cultural/ethnicity, please describe: ___________________

____

Please describe your child's strengths, skills, and talents: ____________________

____

____

Describe any special areas of interest or hobbies (art, books, physical fitness, etc.): ____________________

____

____

Legal Information

If the parents are separated or divorced, what is the current child custody/visitation arrangement?

____

Is your child currently the subject of a custody case? ☐ Yes ☐ No ☐ N/A

Has your child ever been a ward of the court with SCF/DCFS guardianship? ☐ Yes ☐ No ☐ N/A

Does your child have any legal offenses on record or pending in the courts? ☐ Yes ☐ No ☐ N/A

______________________________ ____________________

Signature of the person completing the form Date

______________________________ ____________________

Printed Name Relationship to Client