Today's Date: _____

# Adolescent Intake Form

Please provide the following information and bring this form to your first appointment. If possible, parent(s)/guardian(s) should work with their adolescent to complete this form. All information will be protected as confidential information.

If you are in need of additional space please feel free to write on the back of this form.

Individual(s) completing this form: _____

## Client Information

Name (first and last): _____

Date of Birth: _____Gender (M/F): _____Race/Ethnicity: _____

Address: _____

1 - Parent/Guardian Name: _____

Preferred number: _____May I leave a voicemail? ***Yes*** ***No***

Email: _____May I email you? ***Yes*** ***No***

2 - Parent/Guardian Name: _____

Preferred number: _____May I leave a voicemail? ***Yes*** ***No***

Email: _____May I email you? ***Yes*** ***No***

*(Please note that email is not considered to be a confidential form of communication)*

Parents are currently: Married Divorced Remarried Never married

Custodial Guardian (if applicable): _____

Stepparent(s) (if applicable): _____

Is the parent/guardian involved in any legal proceedings (custody disputes, divorce)? ***Yes*** ***No***

If yes, please explain: _____

Have you, the client, been involved in the legal system? ***Yes*** ***No***

If yes, please explain: _____

_____

School: _____Grade: _____

Please describe your current academic performance: _____

_____

Race/Ethnicity: _____

Spiritual Beliefs: _____

Strengths: _____

Hobbies: _____

Name/Address of financially responsible party: _____

_____

**Primary Concerns**

Main reason for seeking counseling at this time:

_____

_____

_____

_____

_____

_____

**Medical Care**

Clinic Name: _____

Doctor's Name: _____

Phone: _____

Address: _____

May I get a release of information in order to coordinate care with your doctor? ***Yes*** ***No***

**General Health**

Do you have any concerns about your physical health? Please explain:

_____

Are you on any medication for physical/medical issues? ***Yes*** ***No***

Are there any changes or difficulties with your eating habits? ***Yes*** ***No***

If yes, please circle: Eating less Eating more Binging Restricting

Have you experienced any weight changes in the last 1-2 months? ***Yes*** ***No***

Are you having any trouble with your sleep habits? ***Yes*** ***No***

If yes, please describe: _____

**Medical History**

Did adolescent's mother use any of the following during pregnancy *(please circle)*:

Cigarettes Alcohol Drugs Extreme Stress

If so, please specify frequency and duration: _____

List any birth complications: _____

List any medical conditions or history of medical conditions: _____

_____

**Past Psychological/Psychiatric Treatment**

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services in the past? ***Yes*** ***No***

If applicable, which type of treatment: ***Inpatient*** ***Outpatient*** ***Both***

If you have received some form of treatment in the past, please indicate:

**When:** _____

**Provider:** _____

**Reason:** _____

**Results:** _____

Have you ever been prescribed medications for psychiatric or emotional problems? ***Yes*** ***No***

**If yes, please indicate:**

When: _____

Medication: _____

Prescriber of the medication: _____

Reason for medication: _____

**List of Symptoms**

Please circle any of the following that have been of concern recently.

| | | |
|---|---|---|
| Alcohol/Substance use | Fatigue | Oppositional |
| Aggression | Frustrated easily | Panic attacks |
| Anger | Grief/Loss | Phobias |
| Anxiety | Hallucinations | PTSD symptoms |
| Bowel trouble | Headaches | Repetitive thoughts |
| Bullies others | Head banging | Relationship trouble |
| Bullied by others | Homicidal thoughts | Sadness |
| Compulsive | Hurting animals | Self-harm |
| Depressed mood | Impulsive | Sexual acting out |
| Defiant | Irritable | Stomach aches |
| Destructive | Isolation | Stealing |
| Difficulty focusing | Lying frequently | Suicidal thoughts/attempts |
| Difficulty with friends/siblings | Low self-esteem | Withdrawn |
| Disturbed sleep | Mood swings | Worry excessively |
| Eating disorder/Disordered eating | | |

**Family/Individuals in Your Household**

| Name | Age | Gender | Relationship | Living with you? |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | ***Yes No*** |
| _____ | _____ | _____ | _____ | ***Yes No*** |
| _____ | _____ | _____ | _____ | ***Yes No*** |
| _____ | _____ | _____ | _____ | ***Yes No*** |
| _____ | _____ | _____ | _____ | ***Yes No*** |
| _____ | _____ | _____ | _____ | ***Yes No*** |

## Family Mental Health History

| *Issue* | | *Family Member(s)* |
|---|---|---|
| Depression | ***Yes No*** | _____ |
| Anxiety Disorder | ***Yes No*** | _____ |
| Panic Attacks | ***Yes No*** | _____ |
| Bipolar Disorder | ***Yes No*** | _____ |
| Obsessive Compulsive Behavior | ***Yes No*** | _____ |
| Schizophrenia | ***Yes No*** | _____ |
| Alcohol/Substance Abuse | ***Yes No*** | _____ |
| Learning Disability | ***Yes No*** | _____ |
| Trauma History | ***Yes No*** | _____ |
| Domestic Violence | ***Yes No*** | _____ |
| Eating disorder | ***Yes No*** | _____ |

## Substance Use

Do you currently consume alcohol? ***Yes No***

If yes, on average how many drinks per occasion do you consume? _____

How many days per week do you consume alcohol? _____

Do you have a history of problematic use of alcohol? ***Yes No***

Have family members or friends expressed concern about your drinking? ***Yes No***

Do you currently use non-prescribed drugs or street drugs? ***Yes No***

Do you have a history of problematic drug use? ***Yes No***

Do you have a family history of alcohol or drug problems? ***Yes No***

If yes, please describe: _____

_____

_____

**Other**

What are your goals for therapy? What would you like to get out of your time in therapy?

_____

_____

_____

Anything else you would like me to know?

_____

_____

_____

**Insurance Information**

Primary Insurance Company: _____

Insurance Company (800) Number: _____

Name of Insured (Subscriber): _____ Insured's DOB: ___/___/____

Relationship to Subscriber: _____ (Self, Spouse, Child, etc.)

ID Number: _____ Group Number: _____

Subscriber's Employer: _____ Co-Pay: $_____

Secondary Insurance Company: _____

Insurance Company (800) Number: _____

Name of Insured (Subscriber): _____ Insured's DOB: ___/___/____

Relationship to Subscriber: _____ (Self, Spouse, Child, etc.)

ID Number: _____ Group Number: _____

Subscriber's Employer: _____ Co-Pay: $_____

*I authorize Erin K. Gist, MA, LMHC, CMHS to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies, including co-pays, deductibles, failed and late cancelled appointments.*

Signature: _____ Date: _____