

ADOLESCENT INTAKE FORM

Adolescent Information

Today's Date _____

Name _____ Age _____

Parent's & Guardian Information

Adolescent's Biological Parent(s): Married Divorced Separated Deceased Other

Name of Parent(s) or Guardian (s) of Minor: _____

Mom's Occupation _____ Dad's Occupation _____

If divorce, how old was adolescent when it occurred? If so, please provide a copy of divorce decree & parenting plan.

Name of Step Parent(s) _____

Physician's Name: _____

Intake Questions for Minor

Issues of concern today

Any previous counseling? Yes___ No___ With Whom_____

Why did you discontinue/stop? _____

What concerns brought you into counseling at that time? _____

If presently on medication(s), which one(s) _____

Are you or others concerned about your alcohol / drug use?

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Have you experienced physical abuse? Yes___ No___ Sexual Abuse? Yes___ No___
Emotional abuse? Yes___ No___

History of Hospitalization or Surgery_____

Are you currently in a romantic relationship? Yes___ No___

What school do you attend? _____ Grade_____

What are your favorite subjects?_____

Any issues with school?_____

Who are your good friends?_____

Are you involved in any activities at school? Yes___ No___

If so, what? _____

What do you consider to be your strengths?_____

What do you like most about yourself?_____

Are you working? Yes___ No___

If so, where? _____ # of hrs/wk_____

Religious / Spiritual Informaton

Do you consider yourself to be religious? Yes___ No___

If yes, how would you describe your faith?_____

If no, do you / your family consider yourselves to be spiritual? Yes___ No___

Is there any other information that you think is important for me to know about your and /
or your family?_____

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Have you ever experienced?

| | | | |
|------------------------|-------------|----------------------------------|-------------|
| Extreme Depressed Mood | Yes___No___ | Unexplained Losses of Time | Yes___No___ |
| Wild Mood Swings | Yes___No___ | Unexplained Memory Lapses | Yes___No___ |
| Rapid Speech | Yes___No___ | Alcohol / Substance Abuse | Yes___No___ |
| Anxiety | Yes___No___ | Eating Disorder | Yes___No___ |
| Panic Attacks | Yes___No___ | Body Image Problems | Yes___No___ |
| Phobias | Yes___No___ | Repetitive Thoughts (obsessions) | Yes___No___ |
| Sleep Disturbances | Yes___No___ | Suicidal Thoughts | Yes___No___ |
| Hallucinations | Yes___No___ | Suicidal Attempt | Yes___No___ |

Family Mental Health History

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? If Yes, List Family Member, e.g., sibling, parent, aunt, etc.

| | | | |
|-------------------------|-------------|---------------------------|-------------|
| Difficult Family Member | Yes___No___ | Alcohol / Substance Abuse | Yes___No___ |
| Depression | Yes___No___ | Eating Disorder | Yes___No___ |
| Bipolar Disorder | Yes___No___ | Learning Disability | Yes___No___ |
| Anxiety Disorder | Yes___No___ | Trauma History | Yes___No___ |
| Panic Attacks | Yes___No___ | Suicide Attempt(s) | Yes___No___ |

More Serious Mental Illness (please list) _____

Is there any other information that you think is important for me to know about you and / or your family?

Empowering Individual & Relational Changes

612.499.2050

TREATMENT PLAN

Name _____ Date _____

Please complete as best as you can. If you are unsure of your answers, bring your questions in and we will discuss at our first appointment.

Problems (Why I'm Here):

Goals (What I Want):

Indicators: (How do I know I'm making Progress?):

Estimate – How Long to Achieve Goals? _____
(We will figure this out together)

Likelihood (0-100%) of Achieving Goals? _____
(We will figure this out together)

Client Signature / Date

Katy Wait, MA LMFT / Date