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**ADOLESCENT INTAKE FORM (PARENT SECTION)**

Adolescent's Name: _____

Date of Birth: _____ Age: _____ ____Male _____Female

Race/Ethnic Origin: _____

Religious Preference: _____

**CURRENT HOUSEHOLD AND FAMILY INFORMATION**

| Name | Relationship (parent, sibling, etc) | Age | Sex | Type (bio, step, etc) | Living with you? Y/N |
|---|---|---|---|---|---|
| _____ | _____ | ____ | ____ | _____ | _____ |
| _____ | _____ | ____ | ____ | _____ | _____ |
| _____ | _____ | ____ | ____ | _____ | _____ |
| _____ | _____ | ____ | ____ | _____ | _____ |
| _____ | _____ | ____ | ____ | _____ | _____ |

(If additional space is need please list on the back of page)

**Current Reason For Seeking Therapy For Your Adolescent**

Briefly describe the problem for which your adolescent is seeking to have therapy?

_____

_____

What would you like to see happen as a result of therapy?

_____

_____

What is most concerning right now?

_____

_____

**CHILD'S DEVELOPMENT**

1. Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:

_____

2. Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

_____

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes ___ No ___ Not sure_____ If yes,describe:_____

4. Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___ Not sure_____ If yes, describe:

_____

5. Has your child experienced emotional, physical, or sexual abuse? Yes ____ No ____ Not sure _____

If yes, describe: _____

**PSYCHOTHERAPY/COUNSELING HISTORY**

Have your son or daughter previously seen a therapist or counselor? Yes___ No___ If Yes, where:

_____

Approximate Dates of Therapy/Counseling: _____

For what reason did your son or daughter go to therapy/counseling?

_____

Does your son or daughter have a previous mental health diagnosis?

_____

What did you find most helpful in therapy? _____

_____

What did you find least helpful in therapy? _____

_____

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?

_____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Name of medication _____Dates taken_____ Was it helpful? (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____ If so, please describe.

_____

**CHEMICAL USE**

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____ If yes, please explain your concern: _____

_____

**INTERNET/ELECTRONIC COMMUNICATIONS USAGE**

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____ If yes, please explain your concern:

_____

**LEGAL ISSUES**

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

_____

_____

**FAMILY HISTORY**

Are you aware of any birth trauma your son or daughter experienced from age 0-3?

_____

_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

_____

_____

**PARENT'S MARITAL STATUS** (this question refers to the biological parents relationship)

_____Single _____Married (legally) _____Divorced ____Cohabitating _____Divorce in process _____Separated _____Widowed ___Other Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____ If divorced, How much time does your child spend with each parent? Mother_____%, Father _____% (Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Biological Father's Name: _____Birth Date:_____ Age: _____

Total years of education completed: _____ Occupation: _____

Place of Employment:_____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

*Please answer if you are no longer with your child's bio-mother OR check here if you are still with bio-mother___
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Biological Mother's Name: _____Birth Date:_____ Age: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____ Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

*Please answer if you are no longer with your child's bio-father OR check here if you are still with bio-father____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

**FAMILY CONCERNS** Please circle any family concerns that your family is currently experiencing.

fighting Disagreeing about relatives feeling distant Disagreeing about friends Loss of fun

Alcohol use Lack of honesty Drug use Physical fights Infidelity (couple)
Education problems Divorce/separation Financial problems Issues regarding remarriage

Death of a family member Birth of a sibling Abuse/neglect Birth of a child

Inadequate housing/feeling unsafe Inadequate health insurance Job change or job dissatisfaction

Other, please explain _____

**YOUR ADOLESCENT'S STRENGTHS**

What activities do you feel your son or daughter is successful when they try?

_____

_____

What personal qualities would you say your son or daughter has?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

_____

**INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER**

| SYMPTOMS | NONE | MILD | MOD | SEVERE | SYMPTOM | NONE | MILD | MOD | SEVERE |
|---|---|---|---|---|---|---|---|---|---|
| SADNESS | | | | | SELF MUTALATION | | | | |
| APPETITE CHANGES | | | | | RACING THOUGHTS | | | | |
| CRYING | | | | | CUTTING | | | | |
| WEIGHT CHANGES | | | | | RESTLESSNESS | | | | |
| (UNPLANNED CHANGES) | | | | | IMPULSIVITY | | | | |
| SLEEP DISTRUBANCES | | | | | DRUG USE | | | | |
| PARANOID THOUGHTS | | | | | NIGHTMARES | | | | |
| DISSOCIATION | | | | | ALCOHOL USE | | | | |
| POOR CONCENTRATION | | | | | HOPELESSNESS | | | | |
| HYPERACTIVITY | | | | | DECREASED CREATIVITY | | | | |
| INDECISIVENESS | | | | | ELEVATED MOOD | | | | |
| BINGING/PURGING | | | | | EASILY DISTRACTED | | | | |
| LOW ENERGY | | | | | MOOD SWINGS | | | | |
| DECREASED SEX DRIVE | | | | | TRAUMA | | | | |
| EXCESSIVE WORRRY | | | | | FLASHBACKS | | | | |
| UNRESOLVED GUILT | | | | | DISORGANIZED | | | | |
| LOW SELF WORTH | | | | | WORK ISSUES | | | | |
| IRRITABILITY | | | | | ANOREXIA | | | | |
| ANGER ISSUES | | | | | PROBLEMS AT HOME | | | | |
| NAUSEA/ INDIGESTION | | | | | SOCIAL ISOLATION | | | | |
| SPIRITUAL CONCERNS | | | | | PANIC ATTACKS | | | | |
| SOCIAL ANXIETY | | | | | PHOBIAS | | | | |
| HALLUCINATIONS | | | | | FEELING ANXIOUS | | | | |
| LONELINESS | | | | | OBSESSIVE THOUGHTS | | | | |
| PAST SUICIDE ATTEMPTS | | | | | FEELING PANICKY | | | | |
| SUICIDAL THOUGHTS | | | | | GRIEF | | | | |
| HEADACHES | | | | | | | | | |

OTHER Is there anything else you would like to share:

_____

_____

_____