INTAKE FORM FOR PARENT AND ADOLESCENT

This intake form requires information on **BOTH** parent and adolescent. Please **read each section carefully** to understand which section pertains to you and which selection pertains to your adolescent.

CUSTODIAL PARENT/GUARDIAN INFORMATION (Who has legal custody of this adolescent)

___ Both Parents ___ Mother ___ Father ___ Other (complete info. in box)

First Name: _____ MI: _____ Home PH: _____

Last Name: _____ Work PH: _____

Address: _____ DOB: _____ /_____ /_____

_____ ____ Male ____ Female

City: _____ State: _____ Zip: _____

Relation to Client: _____

PARENT INFORMATION

Mother

First Name: _____ Last Name: _____

D.O.B. (mm/dd/yyyy) _____ / _____ / _____ SSN: _____ / _____ / _____

Address:_____ Home PH: _____

_____ Cell PH: _____

Occupation: _____ How Long: _____

Place of Employment: _____

Education (highest grade or degree completed): _____

Other Education or Training: _____

MARITAL STATUS: ____ Married ____ Single ___ Divorced ____ Widowed ____ Co-Habitating

If married: wedding date: _____ / _____ / _____ How many previous marriages? _____

If spouse is step-parent or if you are co-habitating:

Name: _____

Get along with client? ____ Yes ____ No

Father

First Name: _____ Last Name: _____

D.O.B. (mm/dd/yyyy) _____ / _____ / _____ SSN: _____ / _____ / _____

Address:_____ Home PH: _____

_____ Cell PH: _____

Occupation: _____ How Long: _____

Place of Employment: _____

Education (highest grade or degree completed): _____

Other Education or Training: _____

MARITAL STATUS: ____ Married ____ Single ___ Divorced ____ Widowed ____ Co-Habitating

If married: wedding date: _____ / _____ / _____ How many previous marriages? _____

If spouse is step-parent or if you are co-habitating:

Name: _____

Get along with client? ____ Yes ____ No

ADOLESCENT/CLIENT INFORMATION

First Name: _____ Last Name: _____

Gender: ____ Male ____ Female D.O.B. (mm/dd/yyyyy): _____ / ____ / _____

School: _____ Grade: _____

Physician(s) of ADOLESCENT: _____

ADOLESCENT'S MEDICATIONS

Current Medications

Medication	Dosage	Frequency

Past Medications

Medication	Dosage	Frequency

List all persons living in the home with adolescent:

Name	Age	Sex	Relationship to adolescent

List other children not in the home:

Name	Age	Sex	Relationship to adolescent

CHECK ANY OF THE FOLLOWING BEHAVIORS THAT ARE TRUE OF YOUR TEEN

_____ Affectionate
_____ Angry
_____ Argues, "talks back", smart-alecky, defiant
_____ Blames others for his/her actions
_____ Bored
_____ Bullies/intimidates, teases, inflicts pain on others, is bossy to others, picks on, provokes
_____ Cheats
_____ Clings to you too much
_____ Cruel to animals
_____ Concern for others
_____ Conflicts with parents – over persistent rule breaking, money, chores, homework, grades, choices in music/clothes/hair/friends
_____ Complains
_____ Confused
_____ Cries easily, feelings are easily hurt
_____ Dawdles, procrastinates, wastes time
_____ Difficulty with parents' new marriage/new family
_____ Dependent, immature
_____ Developmental delays

_____ Disrupts family activities
_____ Disobedient, uncooperative, refuses, non-compliant, doesn't follow rules
_____ Distractible, inattentive, poor concentration, daydreams, slow to respond
_____ Dropping out of school
_____ Drug or alcohol use
_____ Eating – poor manners, refuses, appetite increase or decrease, odd combinations, overats
_____ Exercise problems
_____ Extracurricular activities interfere with academics
_____ Failure in school
_____ Fearful
_____ Fighting, hitting, violent, aggressive, hostile, threatens, destructive
_____ Fire setting
_____ Friendly, outgoing, social
_____ Guilty
_____ Hard time making and keeping friends
_____ Headaches
_____ Hypochondriac, always complains of feeling sick
_____ Immature, "clowns around", has only younger playmates
_____ Imaginary playmates
_____ Independent
_____ Interrupts, talks out, yells
_____ Lacks organization, unprepared
_____ Lacks interest in things he/she used to like
_____ Lacks remorse
_____ Lacks respect for authority, insults, dares, provokes, manipulates
_____ Learning disability
_____ Legal difficulties: truancy, loitering, panhandling, drinking, vandalism, stealing, fighting, drug sales
_____ Likes to be alone, withdraws, isolates
_____ Lying
_____ Low frustration tolerance, irritability
_____ Moody
_____ Mute, refuses to speak
_____ Nail biting
_____ Nervous
_____ Nightmares
_____ Need for high degree of supervision at home
_____ Obedient
_____ Obesity
_____ Overactive, restless, hyperactive, out-of-seat behaviors, fidgety, noisiness
_____ Oppositional, resists, refuses, does not comply, negativism
_____ Prejudiced, bigoted, insulting, name calling, intolerant
_____ Pouts
_____ Recent move, new school, loss of friends
_____ Relationships with siblings and/or peers are poor – competition, fights, teasing, assaults
_____ Responsible

_____ Runs away
_____ Sad, unhappy
_____ School problems
_____ Sees or hears things that aren't there
_____ Self-harming behaviors – biting or hitting self, head banging, scratching self, cutting, hair pulling
_____ Speech difficulties
_____ Sexual – sexual preoccupation, public masturbations, inappropriate sexual behaviors
_____ Shy, timid
_____ Sleeping trouble: too much or too little
_____ Stomach aches
_____ Strange thoughts
_____ Stubborn
_____ Suicide talk or attempt
_____ Swearing, foul language
_____ Temper tantrums, rages
_____ Thumb sucking, finger sucking, hair chewing
_____ Tics – involuntary rapid movements, noises, or word productions
_____ Teased, picked on, victimized, bullied
_____ Truant – school avoiding
_____ Underactive – slow-moving, slow-responding, lethargic
_____ Uncoordinated, accident-prone
_____ Vomits often
_____ Wetting or soiling the bed or clothes
_____ Will not eat
_____ Withdraws
_____ Work problems – employment, workaholism/overworking, can't keep a job
_____ Rocking or other repetitive movements

Other:

Is there anything causing your family stress right now? ____ Yes ____ No

Explain: _____

_____

_____

Has this teen been subject to neglect, physical, sexual, or emotional abuse? ____ Yes ____ No

If "yes", what form? _____

Is this child at risk for out-of-home placement because of behavior problems? ____ Yes ____ No

If "yes", please explain: _____

_____

_____

What are your teen's assets or strengths? ____

____

____

What have you found to be satisfactory ways to help your teen? _________________________

____

____

COMMENTS: (*Please write anything else you want us to be aware of in this space*)

How were you referred to this center? ____

____

Have you sought counseling before? (Y N) If "YES", Where and When? ______________________________

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THE FOLLOWING PAGES: "Adolescent Confidential Questionnaire"

ARE TO BE COMPLETED BY ADOLESCENT

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Ministry of Counseling and Enrichment
1502 N. 1st Street; Abilene, TX 79601
325.672.9999 ❖ 325.672.5237

Adolescent Confidential Questionnaire

Please fill out the following questions about yourself as completely as possible by writing, checking, or circling the correct answer. This will help the counselor get to know you better.

Name: _____ Date: ____ / ____ / ____

Address: _____ Birthday: ____ / ____ / ___

_____ Age: _____

Home Phone: _____

Whose idea was it for you to come here?

____ Mine
____ Parent(s)
____ other – who? _____

How do you feel about being here?

____ It's fine with me
____ I don't care either way
____ I'm against it

Briefly describe what is happening in your life that brings you to counseling.

How long has this been a problem?

SCHOOL INFORMATION

What school do you attend? _____ Grade: _____

What do you like about school?

What do you dislike about school?

What activities (if any) are you in at school?

ACTIVITIES & INTERESTS

What do you do for fun?

What kind of music do you listen to?

Who are 3 of your favorite artists/groups?

Do you attend a church? ____ Yes ____ No

If "yes", what is the name of your church? _____

HEALTH

How would you rate your overall health? ____ excellent ____ good ____ fair ____ poor

Have you had any recently weight gain or loss? ____ Yes, weight gain ____ Yes, weight loss ___ No

If "yes", how much? _____

FRIENDS

How much time to you spend with friends? ____ a lot ____ some ____ not much

Do you have a best friend? ____ Yes ____ No
If "yes," how long have you known him/her? _____

Do you have a boyfriend/girlfriend? ____ Yes ____ No
If "yes," how long have you been dating? _____

Do people at school tend to label your group of friends (skaters, preps, etc.)? ____ Yes ____ No
If, so, what label are they usually given? _____

FAMILY

List all the people living with you (excluding yourself).

Name	Age	Sex	Relationship

Describe your relationship with your father:

Describe your relationship with your mother:

If you have brothers or sisters, describe your relationship with them:

If you have step-parents, describe your relationship with them:

What relative (not including your parents, brothers, or sisters) are you closest?

Why?

FEELINGS

Check all the feelings you often have:

____ happy	____ irritable	____ confused	____ hyper/energetic
____ worried	____ sad	____ anxious/nervous	____ confident
____ guilty	____ lonely	____ angry	____ bored
____ shy	____ depressed	____ worthless	____ hopeless

Check all the FEARS that you often have:

____ Dark	____ New situations	____ Spending the night away from home
____ Being alone	____ Death	____ Separation from parent
____ School	____ Animals	____ Visiting a friend's home
____ Strangers	____ Other: _____	

DRUG and ALCOHOL USE

How often do you drink?	____ never	____ tried it	____ rarely	____ monthly	____ weekly	____ daily
How often do you smoke cigarettes?	____ never	____ tried it	____ rarely	____ monthly	____ weekly	____ daily
How often do you smoke marijuana?	____ never	____ tried it	____ rarely	____ monthly	____ weekly	____ daily
How often do you use other drugs?	____ never	____ tried it	____ rarely	____ monthly	____ weekly	____ daily

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OTHER INFORMATION

List any major changes in your life over the last 5 years:

If there is any other information you believe would be helpful for the therapist to know, please use the space below to provide it (use back if you needed).