Referred by (if any):_____

Adolescent Client Intake Form

(Please note: The information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.)

- - - - -

Parent/Guardian Information *will also serve as emergency contact(s)				
Name	Phone Number	May I leave a voicemail?	Email	May I send an email?
		Yes / No		Yes / No
		Yes / No		Yes / No
		Yes / No		Yes / No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

- - - - -

Patient Name: _____
(Last) (First) (Middle Initial)

Date of birth: _____ / _____ / _____ Age: _____ Gender: _____

Sexual Orientation(s): _____ Race: _____

Address: _____

Phone Number: _____ May I leave a message? ☐ Yes ☐ No

Email Address: _____ May I email you? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

1. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
   - ☐ No
   - ☐ Yes Previous therapist/practitioner/agency: _____

2. Are you currently taking any prescription medication?
   - ☐ No
   - ☐ Yes Please list: _____

3. Have you ever been prescribed psychiatric medication?
   - ☐ No
   - ☐ Yes Please list and add dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good

2. Please list any specific physical health problems and/or medical diagnosis(es) you have:

_____

3. How many hours of sleep do estimate getting each night? _____

- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep (Waking up frequently throughout the night)
- ☐ Waking up early and unable to fall back asleep
- ☐ Oversleeping
- ☐ No problems with sleep

4. How many times per week do you generally exercise? _____

What types of exercise to you participate in:

_____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

6. Are you currently experiencing overwhelming sadness, grief, or depression?

- ☐ No
- ☐ Yes For approximately how long? _____

Severity, on average, on a scale of 1 (low) – 10 (high) _____ / ___10__

7. Are you currently experiencing anxiety, panic attacks or have any phobias?

- ☐ No
- ☐ Yes For approximately how long? _____

Severity, on average, on a scale of 1 (low) – 10 (high) _____ / ___10__

8. Are you currently experiencing any chronic pain?

- ☐ No
- ☐ Yes Please describe: _____

9. How often do you drink alcohol?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

10. How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

11. Are you currently in a romantic relationship?

- ☐ No
- ☐ Yes How long: _____

On a scale of 1 (low) – 10 (high), how would you rate your level of satisfaction with your relationship? _____ / 10

12. List any significant life changes or stressful events you've experienced recently: (if any)

_____

_____

13. What symptoms are you currently experiencing? (Circle any that apply and feel free to add your own.)

Crying a lot	Low energy	Loss of interest	Moving slowly
Sleeping too much	Poor sleep	Loss of appetite	Wanting to be alone
Irritability	Sadness	Poor concentration	Restlessness
Feeling tense	Impulsivity	Panic attacks	Excessive worry
Agitation	Mood swings	Anger	Nightmares
Shame/guilt	Low motivation	Paranoia	Easily startled
Racing thoughts	Nausea	Upset stomach	Poor memory
Shaking	Headache	Dizziness	Shortness of breath
Loneliness	Numbness	Chills	Embarrassment
Indifference	Sweats	Seeing or hearing things	Rapid heartbeat
Drug dreams	Fatigue	Muscle aches	Poor hygiene/grooming

Other:_____

FAMILY MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle and List Family Member:

Alcohol/Substance Abuse. . . . . yes/no _____

Anxiety. . . . . yes/no _____

Depression . . . . . yes/no _____

Domestic Violence . . . . . yes/no _____

Eating Disorders . . . . . yes/no _____

Obsessive Compulsive Behavior . . . . . yes/no _____

Schizophrenia . . . . . yes/no _____

Suicide Attempts . . . . . yes/no _____

ADDITIONAL INFORMATION

1. Are you currently employed?
   - ☐ No
   - ☐ Yes What is your current employment situation: _____

_____

2. If you are employed, do you enjoy your work? Is there anything stressful about your current work?

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

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