



2500 Willamette Falls Dr. #105,
West Linn, OR 97068

ADOLESCENT INTAKE FORM (ages 12-17)

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-8

CLIENT INFORMATION

Name: _____
Date of Birth: _____ Age: _____ Male Female Other: _____
Phone (Cell): _____ Messages okay? ___ Text reminder okay? ___
Address: _____ City _____ State _____ Zip _____
School: _____ Grade: _____
Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

Do your parents/guardians have access to your electronic communication? (Y/N) _____ Do they have any issues with your use of phone, text, electronic communication? (Y/N) _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? _____

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

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? _____

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

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes No
If yes, what did you find **most helpful** in therapy? _____

If yes, what did you find **least helpful** in therapy? _____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? ___ Yes, ___ No
If yes, how often do you drink? ___ Daily, ___ Weekly, ___ Occasionally, ___ Rarely
If yes, how much do you drink? _____ (#) per time.
Do you currently use Tobacco or Marijuana? ___ Yes, ___ No
If yes, how much do you smoke/chew? _____
Do you currently use any other drugs? ___ Yes, ___ No
If yes, what drugs do you use? _____
If yes, how often do you use? ___ Daily, ___ Weekly, ___ Occasionally, ___ Rarely

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go? _____

____ Inpatient _____ Outpatient

Adolescents (please answer the following with Y/N)

1. Have you ever used more than 1 chemical at the same time to get high? _____
2. Do you avoid family activities so you can use? _____
3. Do you have a group of friends who also use? _____
4. Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

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

FAMILY HISTORY

1. Are you adopted or currently in foster care? _____
2. Are your parents married or divorced? _____
3. Do you think their relationship **is** good? (Y/N/Unsure) _____
4. If your parents are divorced, whom do you primarily live with? _____
3. How often do you see each parent? Mom _____ % Dad _____ %.
4. 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.

FAMILY CONCERNS (Please check 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

Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially: ___outgoing ___shy ___depends on the situation.
2. Are you happy with the amount of friends you have? (Y/N) _____
3. Have you ever been bullied? (Y/N) _____
4. Are your parents happy with your friends? (Y/N) _____
5. Are involved in any organized social activities (e.g. sports, scouts, music)? _____

SCHOOL HISTORY

1. Do you like school? (Y/N) _____
2. Do you attend regularly? (Y/N) _____
3. What are your current grades? _____
4. Do you feel you are doing the best you can at School? (Y/N) _____

INDIVIDUAL CONCERNS

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

*We would like you to know that we have worked with a lot of adolescents and that we respect your privacy and we hope to create an atmosphere where you feel comfortable sharing. You may give this form to your parent/guardian or you can bring it in yourself.



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Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____
 Date of Birth: _____ Age: _____ Male Female Other: _____
 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 Counseling For Your Adolescent.

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

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

What is most concerning right now?

ADOLESCENT'S DEVELOPMENT

1. Was/Is this adolescent in foster care or adopted? Yes ___ No ___ If yes, describe: _____

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

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

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

- Did your adolescent have any unusual behaviors or problems prior to age 3? Yes ___ No ___
Not sure _____ If yes, describe: _____

5. Has your adolescent experienced emotional, physical, or sexual abuse?
Yes ___ No ___ Not sure _____ If yes, describe: _____

COUNSELING HISTORY

Has your adolescent previously seen a counselor? Yes No
If Yes, where: _____
Approximate Dates of Counseling: _____
For what reason did your son or daughter go to counseling? _____

Does your adolescent have a previous mental health diagnosis? _____
What did you find **most helpful** in therapy?

What did you find **least helpful** in therapy?

Has your adolescent used psychiatric services? Yes ___ No ___
If yes, who did they see? _____ If yes, was it helpful? N/A ___ Yes ___ No ___

Has your adolescent taken medication for a mental health concern? Yes _____ No _____

Name of medication	Dates taken	Was it helpful? (Y/N)

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

CHEMICAL USE

Do you have any concerns with your adolescent using alcohol or drugs? (Y/N) _____

If yes, please explain your concern: _____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your adolescent 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, your family, or your adolescent, at present, or past if it has had a significant effect upon you or your adolescent in the past.

FAMILY HISTORY

Are you aware of any birth trauma your adolescent 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/GUARDIANS MARITAL STATUS

Single Married (legally) Divorced Cohabiting Divorce in process Separated Widowed

___Other If Divorced please indicate custody agreement: _____

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? Parent 1_____% , Parent 2 _____%

(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.)

Parent 1 Name: _____ **Birth Date:** _____ **Age:** _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

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

Assessment of current relationship with adolescent, if applicable: Poor____ Fair____ Good_____

Parent2 Name: _____ **Birth Date:** _____ **Age:** _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

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

Assessment of current relationship with adolescent, if applicable: Poor _____ Fair _____ Good _____

FAMILY CONCERNS

Please check 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

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your adolescent is successful when they try? _____

What personal qualities would you say your adolescent has? _____

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

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR ADOLESCENT

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGES (UNPLANNED CHANGES)				
SLEEP DISTURBANCES					PARANOID THOUGHTS				
DISSOCIATION					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/PURGING					LOW ENERGY				
DECREASED SEX DRIVE					EXCESSIVE WORRY				
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ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					WORK ISSUES				
ANOREXIA					PROBLEMS AT HOME				
SOCIAL ISOLATION					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
OBSESSIVE THOUGHTS					FEELING PANICKY				
GRIEF					SUICIDAL THOUGHTS				
HEADACHES					PAST SUICIDE ATTEMPTS				
LONELINESS					OTHER				

Is there anything else you would like to share: _____
