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Teen Intake Form

Please fill out this form and bring it to your teen's initial session.
I encourage you to ask for your teen's input for the questions in the "additional Information" section.
Please note, the information provided here is protected as confidential information.

Teen Client's Name_____Gender at birth_____Age_____

Date of Birth _____

Client's Cell_____Client's Email _____

School Name _____Grade in School _____

Who referred you to my practice?_____

Has the client ever been in therapy before? □ No □ Yes If yes, with whom? _____

Reason for previous therapy? _____

Reason for ending previous therapy? _____

Mother's Name _____

Address_____City, State Zip _____

Home ph. _____ Work ph. _____ Cell ph. _____

Email _____

Occupation _____ Employer _____

Father's Name _____

Address_____City, State Zip _____

Home ph. _____ Work ph. _____ Cell ph. _____

Email _____

Occupation _____ Employer _____

Best contact? Mother ____ Father ____ **Best way to contact parent**? Text _____ Phone _____ Email _____

Party financially responsible for teen client's therapy _____

Parent's Marital Status □ Married □ Separated □ Divorced □ Widowed □ Domestic Partnership

If parents are divorced/separated:

Client lives with? _____

Custody arrangement: _____

_____

Siblings:

Name	Age	Gender	School	Grade

Intake form continued on the next page…

Teen Client's History:

1. Does the client have any **learning differences**? □ No □ Yes If yes, was the client tested? □ No □ Yes
   When? _____ By Whom? _____ Diagnosis _____
2. Does the client have a **mental health** diagnosis? □ No □ Yes
   If yes, what is the diagnosis? _____
   When was the client diagnosed? _____ Who made the diagnosis? _____
3. **How would you rate your current physical health?** (Please circle)
   Poor Unsatisfactory Satisfactory Good Very good
4. **How would you rate your current sleeping habits?** (Please circle)
   Poor Unsatisfactory Satisfactory Good Very good
5. **Please list any sleep problems you are currently experiencing** _____

_____

6. Are you currently experiencing **sadness, or depression**? □ No □ Yes
   If yes, for how long? _____
7. Rate the severity of these feelings on a scale of 1-5 (5 is most severe) _____
8. History of previous **suicide attempts**? □ No □ Yes Number of attempts_____
9. Are you currently having suicidal thoughts? □ No □ Yes
10. History of **self-harm/cutting** behaviors? □ No □ Yes If yes, when was the last time? _____
11. Does client use **drugs or alcohol**? □ No □ Yes
    If yes, how often? □ Daily □ Weekly □ On weekends □ Monthly
12. What type of substances are currently being used (marijuana, alcohol, opioids)? _____

_____

13. Does the client have a history of **trauma** (physical or emotional)? □ No □ Yes
14. If yes, how old was the client when the trauma occurred? _____
15. Was the trauma ongoing? □ No □ Yes If yes, for how long? _____
16. Please describe the type of trauma: _____

_____

17. Does the client have a history of an **eating disorder**? □ No □ Yes
    If yes, what type of eating disorder? _____
18. Are you currently experiencing **anxiety**? □ No □ Yes If yes, how long? _____
    Rate the severity of the feeling on a scale of 1-5 (5 is most severe) _____
19. Is the client struggling with gender identity issues? □ No □ Yes If yes, explain: _____

_____

20. Is the client struggling with sexual orientation issues? □ No □ Yes If yes, explain _____

_____

Intake form continued on the next page…

Teen's Primary Physician_____**Phone**_____

List Client's current medications and diagnoses (if applicable)?

Condition/Diagnosis	Medication	Dosage	Date Started	Name of Prescribing Physician

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 the client in the space provided (father, mother, grandmother, uncle, etc.):

Anxiety □ No □ Yes _____

Bipolar Disorder □ No □ Yes _____

Depression □ No □ Yes _____

Domestic Violence □ No □ Yes _____

Eating Disorders □ No □ Yes _____

Obsessive Compulsive Behavior □ No □ Yes _____

Schizophrenia □ No □ Yes _____

Substance Abuse/Addiction □ No □ Yes _____

Suicide Attempts □ No □ Yes _____

Additional Information:

What is the primary reason for wanting therapy at this time?

_____

_____

_____

How long has the problem existed? _____

What attempts (if any) have been made to resolve these issues/concerns?

_____

_____

_____

Have there been any significant stressors in the past several years? (ex. bullying, divorce, births, deaths, moves, hospitalizations, and or financial problems)

_____

_____

Intake form continued on the next page…

What do you consider some of your strengths?

What do you consider some of your weaknesses?

What would you like you to accomplish in therapy?