HOPE & HARBOR

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ADOLESCENT INTAKE (ages 12-17)

Welcome to It's Just Therapy. Please note that this information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

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

CLIENT INFORMATION

Name: _____
Date of Birth: _____ Age: _____ _____ Male _____ Female
Phone (Cell): _____ Messages okay?____ Text reminder okay?_____
School: _____ Grade: _____
Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc.) that you use:
_____
Do your parents 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 at when you try? _____
_____

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

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem that is the reason you are seeking counseling? _____
_____
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? _____
_____

FAMILY HISTORY

1. Are your parents married or divorced? **_____**

2. Do you think their relationship is good? (Y/N/Unsure)_____

3. If your parents are divorced, whom do you primarily live with? _____

4. How often do you see each parent? Mom_____% Dad _____%.

5. 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 concerns that your family is currently experiencing.*)

Arguing
Drug use Alcohol use Physical fights Abuse/neglect Unsafe

Disagreeing about relatives Disagreeing about friends Education problems Divorce/Separation Infidelity (couple)

Death of a family member Inadequate health insurance Job change or job dissatisfaction

_____

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) _____

Birth of a child
Childcare issues
Other concerns not listed above:

Feeling distant
Loss of fun
Lack of honesty
Financial problems
Issues regarding remarriage Birth of a sibling Inadequate housing

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 (*Please check any concerns that you have experienced within the past month, including today.*)

_____
_____
_____

Sadness Loneliness Low Energy Cutting Hopelessness Anger Issues Grief Disorganized Indecisiveness Drug Use Panic Attacks Stress

Temper Other:

Crying Irritability Impulsivity Nightmares Headaches Anorexia Phobias
Mood Swings Low Self Worth Alcohol Use Feeling Anxious Stomachaches Nervousness

Sleep Problems Hyperactivity Nausea/Indigestion Poor Concentration Paranoid Thoughts Elevated Mood Easily Distracted Social Anxiety Weight Changes Restlessness Feeling Panicky Health Problems Academic Problems

Problems at Home Appetite Changes Social Isolation Unresolved Guilt Excessive Worry Racing Thoughts Trauma Flashbacks Binging/Purging Spiritual Concerns Obsessive Thoughts Suicidal Thoughts Feeling Depressed Allergies

_____

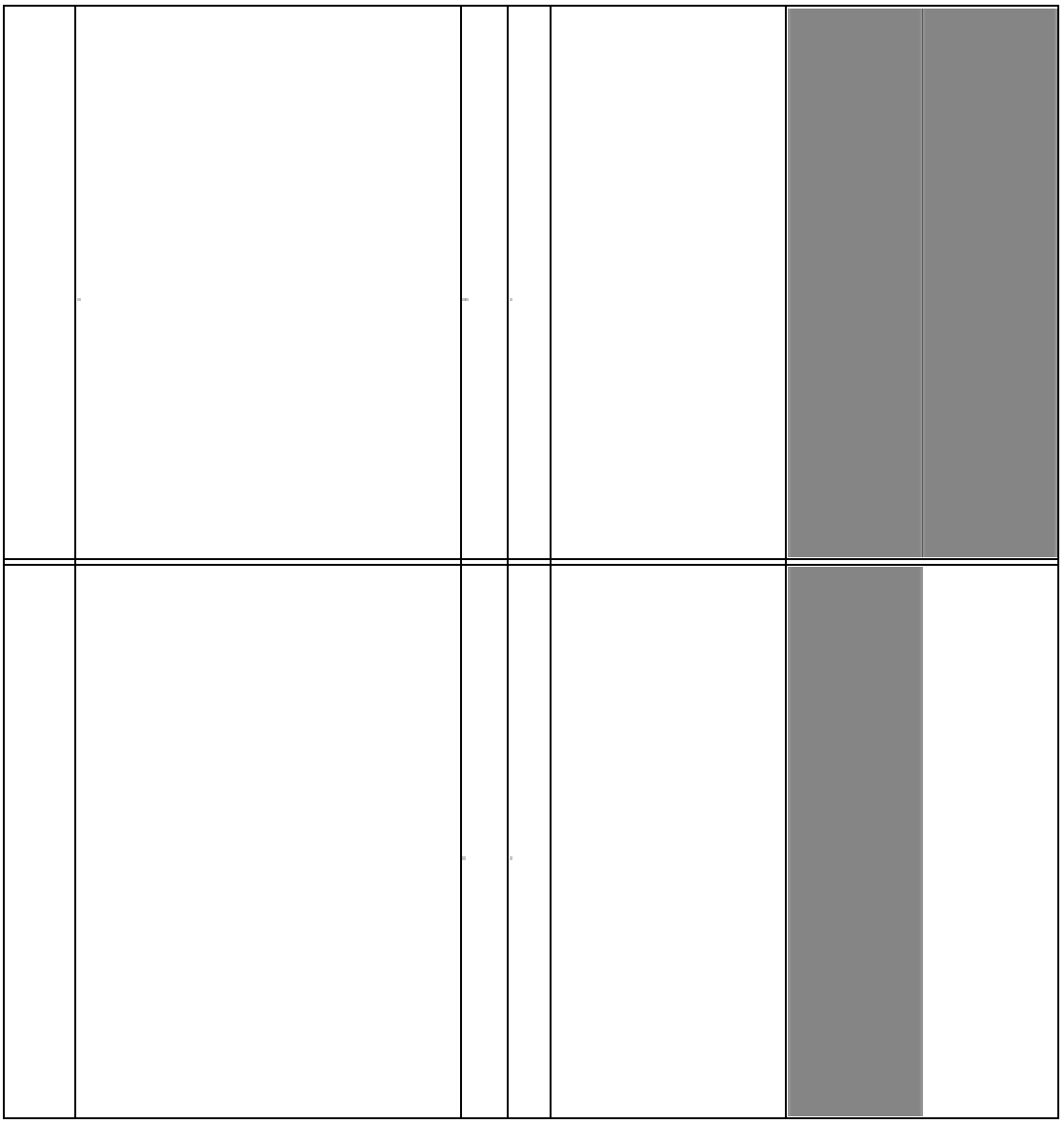
ADOLESCENT INTAKE FORM (PARENT SECTION)

Welcome to It's Just Therapy. 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'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 Counseling For Your Adolescent.

Briefly describe the problem that is the reason your adolescent is seeking counseling? _____

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

COUNSELING HISTORY

1. Have your son or daughter previously seen a counselor?
Yes ____ No ____ Not sure _____ If yes, where: _____

2. Approximate Dates of Counseling: _____
3. For what reason did your son or daughter go to counseling? _____
_____
4. Does your son or daughter have a previous mental health diagnosis? _____
5. What did you find **most helpful** in therapy? _____
_____
6. What did you find **least helpful** in therapy? _____
_____
7. 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_____
8. Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

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

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

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) INFORMATION

_____Single _____Married (legally) _____Divorced _____Cohabitating _____Divorce in process
_____Separated _____Widowed Other/Further Details: _____

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.)

Parent's Name: _____Birth Date:_____ Age: _____

Address: _____
Email: _____ Work phone: _____
Cell phone: _____ Ethnic Origin: _____

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 other parent OR check here if you are still with co-parent____*

Assessment of current relationship, if applicable: Poor_____ Fair_____ Good_____

Parent's Name: _____Birth Date:_____ Age: _____

Address: _____
Email: _____ Work phone: _____
Cell phone: _____ Ethnic Origin: _____

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 other parent OR check here if you are still with co-parent____*

Assessment of current relationship, if applicable: Poor_____ Fair_____ Good_____ **FAMILY CONCERNS** (*Please check any family concerns that your family is currently experiencing.)*

Arguing
Drug use Alcohol use Physical fights Abuse/neglect Unsafe

Birth of a child Childcare issues

Disagreeing about relatives Disagreeing about friends Education problems Divorce/Separation

Issues regarding remarriage Death of a family member Inadequate health insurance Job change or job dissatisfaction

Feeling distant
Loss of fun
Lack of honesty Financial problems Infidelity (couple) Birth of a sibling Inadequate housing Other:

YOUR ADOLESCENT'S STRENGTHS

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

_____

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

_____

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

_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

Please check any symptoms that your child has experienced.

Sadness Loneliness Low Energy Cutting Hopelessness Anger Issues Grief Disorganized Indecisiveness Drug Use Panic Attacks Stress

Temper Other:

Crying Irritability Impulsivity Nightmares Headaches Anorexia Phobias
Mood Swings Low Self Worth Alcohol Use Feeling Anxious Stomachaches Nervousness

Sleep Problems Hyperactivity Nausea/Indigestion Poor Concentration Paranoid Thoughts Elevated Mood Easily Distracted Social Anxiety Weight Changes Restlessness Feeling Panicky Health Problems Academic Problems

Problems at Home Appetite Changes Social Isolation Unresolved Guilt Excessive Worry Racing Thoughts Trauma Flashbacks Binging/Purging Spiritual Concerns Obsessive Thoughts Suicidal Thoughts Feeling Depressed Allergies

_____

Is there anything else you would like to share? _____
_____
_____