# TEEN INTAKE FORM

NAME: _____ DATE: _____

AGE: _____ DATE OF BIRTH: _____

SEX: Male Female

HOME ADDRESS: _____

_____

YOUR CELL PHONE:_____ — ok to leave a message? Y/N

HOME PHONE: _____ — ok to leave a message? Y/N

EMAIL: _____ — ok to leave a message? Y/N

MOTHER'S CELL PHONE: _____ — ok to leave a message? Y/N

FATHER'S CELL PHONE: _____ — ok to leave a message? Y/N

HOW WOULD YOU LIKE ME TO CONTACT YOU? _____

BIRTHPLACE: _____

GRADE IN SCHOOL: _____

NAME OF SCHOOL: _____

EXTRACURRICULAR ACTIVITIES: _____

_____

WORK (IF APPLICABLE): _____

ARE YOU CURRENTLY DATING OR IN A RELATIONSHIP? _____

HAVE YOU RECENTLY BROKEN UP OR ENDED A RELATIONSHIP?_____

 CLIENT NAME:_____

PARENTS:

PARENT 1 NAME: _____

PARENT 1 AGE AND OCCUPATION:_____

PARENT 2 NAME: _____

PARENT 2 AGE AND OCCUPATION: _____

ARE YOUR PARENTS MARRIED, SEPARATED, OR DIVORCED?_____

PLEASE LIST NAMES OF STEP PARENTS IN YOUR LIFE (IF APPLICABLE):

_____

_____

SIBLINGS:
Please list ages and occupations (if applicable) and if they are half or full siblings.

NAME: _____

_____

NAME: _____

_____

NAME: _____

_____

NAME: _____

_____

NAME: _____

 CLIENT NAME:_____

PHYSICIAN'S NAME:_____

PHYSICIAN'S PHONE NUMBER:_____

MAY I CONTACT THEM? _____
(in order for me to do so, you will need to give your permission by signing a consent)

ARE THERE ANY MEDICAL CONDITIONS I SHOULD KNOW ABOUT? _____

_____

CURRENT MEDICATIONS:

NAME OF MEDICATION/ DOSE/ FREQUENCY

_____

_____

_____

_____

ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST? _____

PSYCHIATRIST NAME (IF APPLICABLE): _____

PSYCHIATRISTS PHONE NUMBER (IF APPLICABLE): _____

MAY I CONTACT THEM? _____
(in order for me to do so, you will need to give your permission by signing a consent)

REFERRAL SOURCE (who referred you or how did you hear about my services):

_____

 CLIENT NAME:_____

CURRENT OR PREVIOUS COUNSELING, TREATMENT, AND/OR SUPPORT GROUP EXPERIENCE:

_____

_____

ANY FAMILY OR PERSONAL HISTORY OF MENTAL ILLNESS, ALCOHOLISM, SUBSTANCE ABUSE, SUICIDAL THOUGHTS, OR SUICIDAL ATTEMPTS?

_____

_____

_____

ARE YOU HAVING SUICIDAL THOUGHTS NOW? _____

PLEASE DESCRIBE WHY YOU ARE SEEKING THERAPY: _____

_____

_____

THANK YOU FOR PROVIDING THE ABOVE INFORMATION. PLEASE UPDATE ME IF YOUR ANSWERS CHANGE TO ANY OF THESE QUESTIONS.