Courage to Connect Counseling, PLLC

Adolescent Intake Form

Please complete this form a fully as possible.

General Information

Today's Date: ______/_______/__________

Phone:______________________

Is it ok to text/leave a voicemail? ☐ Yes ☐ No

Name: ______________________________________DOB: ____/_______/______ Age: ________________

First Last MI

Gender (as identified): ☐ Male ☐ Female

Race/Ethnicity: _________________________________

Is culture important to you: ☐Yes ☐ No ☐ Neither

Whose idea was it for you to come to counseling? ____

What do you think about being here? ☐ Great ☐ Fine ☐ I Don't Care ☐ Against It

School

School:____ Grade:____________________________

Do you like school? ☐ Yes ☐ No Do you skip school often? ☐ Yes ☐ No

What activities do you do in school (sports, music etc.)? ____

____

What do you like the most about school?_______________________ Least?____________________________

What hobbies you do for fun?____

What activities would you like to do that you haven't yet?____

Do you think you have good grades? ☐ Yes ☐ No ☐ Don't Care Do you parents agree? ☐ Yes ☐ No

Would you like to improve your grades? ☐ Yes ☐ No ☐ Maybe ☐ Don't Care

Do you feel you are doing the best in school that you care capable? ☐ Yes ☐ No

Peer & Social Information

How do you consider yourself socially: ☐ Outgoing ☐ Shy ☐ Depends on the Situation

Have you ever been bullied? ☐ Yes ☐ No Do you normally bully others? ☐ Yes ☐ No

Are you happy with the amount of friends you have? ☐ Yes ☐ No

How much time do you spend with peers your age? ☐ None ☐ Little ☐ Some ☐ Alot

Are you satisfied with this amount of time? ☐ Yes ☐ No

Are you satisfied with the quality of these friendship? ☐ Yes ☐ No

Do you typically do age appropriate activities with your friends? ☐ Yes ☐ No ☐ No Answer

Are your parents satisfied with your friends? ☐ Yes ☐ No

Do you have a best friend? ☐ Yes ☐ No How long have you been friends? ______________________

What do you like the most about him/her?____

Do you have someone you can talk to about personal issues? ☐ Yes ☐ No Who?___________________

Do you have a girlfriend/boyfriend? ☐ Yes ☐ No Length of relationship:_________________________

If no, do you wish you did? ☐ Yes ☐ No ☐ Don't Care

Are you sexually active? ☐ Yes ☐ No ☐ No Answer Do you sext? ☐ Yes ☐ No ☐ No Answer

Do you view porn? ☐ Yes ☐ No ☐ No Answer

What do you like to do in your spare time:

☐ Play video games ☐ Music

☐ Hang with friends ☐ Dance

☐ Be by myself ☐ Be outside

☐ Sports ☐ Other: _________________________________

☐ Social Media

How do you access internet (phone, tablet etc.)?____

What do you use the internet for? ____

How many hours a day are you online? ___________

Which social media outlets do you use (facebook, twitter, snapchat etc.)?________________________________

____

Do you parents have access to your accounts? ☐ Yes ☐ No ☐ Some

Substance Use

Do you currently use alcohol? ☐ Yes ☐ No If so, last use?____________________________

If yes, how often do you drink?

☐ Daily ☐ Weekly ☐ Occasionally ☐ Tried once or twice ☐ Rarely

If yes, how much do you drink? ____________(#) per time.

Do you currently use Tobacco? ☐ Yes ☐ No If so, last use?____________________________

If yes, how often do you smoke/chew?

☐ Daily ☐ Weekly ☐ Occasionally ☐ Tried once or twice ☐ Rarely

Do you currently smoke marijuana? ☐ Yes ☐ No If so, last use?____________________________

If yes, how often do you participate?

☐ Daily ☐ Weekly ☐ Occasionally ☐ Tried once or twice ☐ Rarely

Do you currently use any other drugs? ☐ Yes ☐ No If so, last use?__________________________

If yes, what drugs do you use? ____

If yes, how often do you use?

☐ Daily ☐ Weekly ☐ Occasionally ☐ Tried once or twice ☐ Rarely

Have you received any previous treatment for chemical use? ☐ Yes ☐ No When?__________________

If so, where did you go?____ ☐ Inpatient ☐ Outpatient

Family History

Are you parents married, separated, or divorced? ______________________

How is their current relationship? ☐ Awful ☐ Alright ☐ Good ☐ Great

If your parents are not together who do you primarily live with? __________________

Would this be your parent of choice to live with? ☐ Yes ☐ No ☐ Doesn't Matter

What percent of time do you spend with each parent? Mom-______________% Dad-______________%

Did you experience any abuse (physical, emotional, verbal, sexual) inside or outside the home? ☐ Yes ☐ No

If yes and you feel comfortable, can you briefly explain?____

____

Will you check any of the following that are frequent issues in your family:

☐ Fighting	☐ Lack of honesty	☐ Financial problems
☐ Disagreeing about relatives	☐ Drug use	☐ Issues regarding remarriage
☐ Feeling distant	☐ Physical fights	☐ Death of a family member
☐ Disagreeing about friends	☐ Infidelity (couple)	☐ Birth of a sibling
☐ Loss of fun	☐ Education problems	☐ Abuse/neglect
☐ Alcohol use	☐ Divorce/separation	☐ Birth of a child

☐ Inadequate housing ☐ Inadequate health insurance ☐ Emotional Withdrawal

☐ Feeling unsafe ☐ Job Issues

Describe your family in a few words: ____

____

Who do you get along with the best in your family? ____________________________________

What would you change about your family if you were given the power to do so? ________________

____

What is your family's greatest strength? ____

Individual Concerns

On a scale of 1(being worst) to 10(being best) how would you rate your physical health currently? _______

Can you list any physical symptoms or health concerns you have? ______________________________

____

Are you on any medications for physical injury or illness? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No If no, do you want to? ☐ Yes ☐ No

How many times per week do you exercise? __________days __________minutes/hours

Are there any changes or difficulties with your eating habits? ☐ Yes ☐ No

If yes, how so? ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced a significant weight change in the last 3 months? ☐ Ye
s

Are you having any problems with your sleep habits? ☐ Yes ☐ No

If yes, how so? ☐ Sleep too much ☐ Sleep too little ☐ Poor quality ☐ Disturbing

Other: ____

Can you explain?____

Check all items that you struggle with:

☐ Sadness ☐ Problems at Home ☐ Low Energy

☐ Appetite Changes ☐ Poor Concentration ☐ Loneliness

☐ Crying ☐ Hyperactivity ☐ Excessive Worry

☐ Social Isolation ☐ Indecisiveness ☐ Unresolved Guilt

☐ Sleep Disturbances ☐ Binging/Purging ☐ Low Self Worth

☐ Paranoid Thoughts ☐ Anorexia ☐ Irritability

☐ Anger Issues
☐ Nausea/Indigestion
☐ Headaches
☐ Spiritual Concerns
☐ Social Anxiety
☐ Hallucinations
☐ Self Harm
☐ Racing Thoughts
☐ Impulsiveness

☐ Restlessness
☐ Drug/Alcohol Use
☐ Nightmares
☐ Hopelessness
☐ Elevated Mood
☐ Traumatic Flashbacks
☐ Mood Swings
☐ Obsessive Thoughts
☐ Disorganized Thoughts

☐ Panic Attacks
☐ Anxiety
☐ Phobias
☐ Suicidal Thoughts

Other:
____
____
____

Check all the feelings you have regularly:

☐ Happy	☐ Sad	☐ Angry	☐ Irritable
☐ Anxious	☐ Nervous	☐ Bored	☐ Confused
☐ Confident	☐ Shy	☐ Guilty	☐ Hyper or Energetic
☐ Depressed	☐ Worried	☐ Lonely	☐ Worthless

Are you currently having thoughts of Suicide*? ________________ Of Homicide*? ________________

Have you attempted suicide in the past? ☐ Yes ☐ No How many times? _______ When? _______________

Have you intentionally burned, cut, or hurt yourself? ☐ Yes ☐ No

If yes, when and how did it first start? ____
____

How often? ______________ When was the last time?__________

**Please Note: The law requires me to break confidentiality to save lives.*

What are your strengths?
____
____
____

What are areas that need development?
____
____
____

Current Major Stressors in your life:
____
____
____

Major Source of Support in your life:
____
____
____

What are your dreams for the future? ____

____

Please list any major changes in your life over the past five years (moving, parents divorce, etc.):

____

What would <u>you</u> like to accomplish in our time together in counseling?____________________________

____

____

Anything else you want me to know about you? ____

____

____