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Adolescent, Teen and Young Adult Intake Form

Client's Name _____ Age_____Date of birth_____

Gender at birth_____Current gender identity: ☐ Male ☐ Female ☐ Transgender

☐ Transgender Female/Transwoman/MTF ☐ Gender Queer ☐ Other (please specify)_____

☐ Decline to answer

Sexual Orientation: Do you identify as: (check all that apply) ☐ Straight ☐ Gay ☐ Lesbian ☐ Bisexual ☐ Other.

What pronouns do you prefer? (Check all that apply) ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other.

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 _____

Client's Cell_____Client's Email _____

Best contact? Mother____Father_____ Best way to contact? Home ____ Work ____ Cell ____Email___

Party financially responsible for teen client's therapy _____

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

If parents are divorced/separated, with whom does the client live? _____

Custody arrangement: _____

Client's History:

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

Condition/Diagnosis	Medication	Dosage	Date Started	Prescribing Physician

1. Does the client have any **learning differences**? ☐ No ☐ Yes
2. If yes, has the client been tested? ☐ No ☐ Yes
   When?_By Whom?_____ Diagnosis _____
   _____
3. Does the client have a **mental health** diagnosis? ☐ No ☐ Yes
   If yes, what is the diagnosis? _____
   When was the client diagnosis made?_____Who made the diagnosis? _____
4. How would you rate your **current physical health**?
   (Please circle your answer) Poor Unsatisfactory Satisfactory Good Very good
5. How would you rate your **current sleep habits?**
   (Please circle your answer) Poor Unsatisfactory Satisfactory Good Very good.
6. Please explain any **sleep problems** you are currently experiencing.
   _____
7. Are you currently experiencing **anxiety**? ☐ No ☐ Yes
   If yes, for how long? _____
   Rate the severity of the anxiety on a scale of 1-5 (5 being most severe) ____

8. Are you currently experiencing **depression**? ☐ No ☐ Yes

   If yes, for how long?_____

   Rate the severity of these feelings on a scale of 1-5 (5 being most severe) _____

9. History of previous **suicide attempts**? ☐ No ☐ Yes Number of attempts___
10. Are you currently having **suicidal thoughts**? ☐ No ☐ Yes
11. History of **self-harm/cutting** behaviors? ☐ No ☐ Yes If yes, when was the last time? _____
12. Does client use **drugs or alcohol**? ☐ No ☐ Yes

    If yes, how often? ☐ Daily ☐ Weekly ☐ On weekends ☐ Monthly

    What type of substances are currently being used (marijuana, alcohol, opioids)___
13. Does the client have a history of **trauma**? (Physical, sexual, emotional or other) ☐ No ☐ Yes If yes, how old was the client when the trauma occurs? _____

    Please describe the type of trauma: _____
14. Does the client have a history of an **eating disorder**? ☐ No ☐ Yes

    If yes, what type of eating disorder? _____

Client's History, (cont.):

15. Is the client struggling with **gender identity** issues? ☐No ☐ Yes If yes, explain: _____
16. Is the client struggling with **sexual orientation** issues? ☐ No ☐ Yes If yes, explain _____

Family History:

Siblings:

Name	Age	Gender	School	Grade

Family Mental Health History: (In the section below, identify any family members with a history of any of the following. If yes, please indicate in the space provided, the family member's relationship to the client i.e., father, mother, grandmother, uncle, etc.):

Anxiety: ☐ No ☐ Yes _____

Bipolar Disorder: ☐ No ☐ Yes _____

Depression: ☐ No _____

Domestic Violence: ☐ No ☐ Yes

Eating Disorders: ☐□ No ☐ Yes _____

Obsessive Compulsive Behavior: ☐ No ☐ Yes _____

Schizophrenia: ☐ No ☐ Yes _____

Substance Abuse/Addiction: ☐ No ☐ Yes _____

_____

_____

Suicide: ☐ No ☐ Yes _____

Presenting Issue: (Please have the client answer the following questions**):**

What is the primary reason for wanting therapy currently?

_____

_____

_____

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. divorce, births, deaths, moves, hospitalizations, and or financial problems)

_____

_____

_____

What do you consider some of your strengths?

_____

_____

_____

What aspects of yourself would you like to improve?

What would you like you to accomplish in therapy?