

Adolescent Intake Form

True Living Counselling

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Welcome to True Living Counselling. Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session. Please do not answer any question you do not understand or want to answer at this time.

ADOLESCENT INTAKE FORM (ages 12-17) Adolescent please fill out pages 1-4, parent/guardian please fill out pages 5-10

How did you hear about True Living Counselling? _____

CLIENT INFORMATION – Adolescent complete pages 1-4

Name: _____ Date of Birth: _____ Age: _____

Name of Family Doctor: _____

Phone (Cell): _____ Messages 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 when you try?

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

CURRENT REASON FOR SEEKING COUNSELING Briefly describe the problem for which you are seeking to have counseling for?

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

COUNSELLING/MEDICAL HISTORY

Have you previously seen a counselor? If yes, what did you find most helpful in therapy?

If yes, what did you find least helpful in therapy? _____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____ Yes, _____ No If yes, how often do you drink? _____ Daily,
_____ Weekly, _____ Occasionally, _____ Rarely If yes, how much do you drink? _____ (#) per
time.

Do you currently use Tobacco? _____ Yes, _____ No If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____ Yes, _____ No If yes, what drugs do you use?
_____ If yes, how often do you
use? _____ Daily, _____ Weekly, _____ Occasionally, _____ Rarely

Have you received any previous treatment for chemical use? Y/N _____ If so, where did you
go? _____

Please answer the following with Y/N

1. Have you ever used more than 1 chemical at the same time to get high? _____
2. Do you avoid family activities so you can use? _____
3. Do you have a group of friends who also use? _____
4. Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant
effect upon you in the past. _____

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 circle any family concerns that your family is currently experiencing)

1. Fighting 2. Disagreeing about relatives 3. Feeling distant 4. Disagreeing about friends 5. Loss of fun 6. Alcohol use 7. Lack of honesty 8. Drug use 9. Physical fights 10. Infidelity (couple)
 11. Education problems 12. Divorce/separation 13. Financial problems 14. Issues regarding remarriage 15. Death of a family member 16. Birth of a sibling 17. Abuse/neglect 18. Birth of a child 19. Inadequate housing 20. Feeling unsafe 21. Job change or job dissatisfaction

Other concerns not listed above _____

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) _____
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 EACH SYMPTOM- NONE, MILD, MODERATE, SEVERE

SYMPTOMS	None	Mild	Moderate	Severe	SYMPTOMS	None	Mild	Moderate	Severe
SADNESS					RACING THOUGHTS				
HEADACHES					LOW ENERGY				
APPETITE CHANGES					OBSESSIVE THOUGHTS				
WEIGHT CHANGES					UNPLANNED CHANGES				
CRYING					LONELINESS				
SUICIDAL THOUGHTS					GRIEF				
SLEEP DISTURBANCES					PROBLEMS AT HOME				
PARANOID THOUGHTS					FEELING PANICKY				
POOR CONCENTRATION					MOOD SWINGS				
BINGING/PURGING					IMPULSIVITY				
EXCESSIVE WORRRY					PHOBIAS				
PAST SUICIDE ATTEMPTS					ANGER ISSUES				
ANOREXIA					IRRITABILITY				
FEELING ANXIOUS					GUILT				
PANIC ATTACKS					SOCIAL ISOLATION				
TRAUMA FLASHBACKS					SOCIAL ANXIETY				
WORK ISSUES					LOW SELF WORTH				
HYPERACTIVITY					EASILY DISTRACTED				
CUTTING/BURNING					HOPELESSNESS				
RESTLESSNESS					NIGHTMARES				
OTHER:					OTHER:				

Is there anything else you would like to share: _____

Parent/Guardian Section

ADOLESCENT INTAKE FORM (PARENT SECTION)

How did you hear about True Living Counselling? _____

Adolescent's Name: _____

Date of Birth: _____ Age: _____

Home Address: _____

Parent

Name: _____ Date of Birth _____

Phone number: _____

Parent

Name: _____ Date of Birth _____

Phone number: _____

How did you find True Living Counselling? _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name, Relationship (parent, sibling, etc), Age, Type (biological, step, etc) Living with you? Y/N

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Current Reason for seeking counseling for your adolescent. Briefly describe the problem for which your adolescent is seeking to have counseling for?

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

Have your son or daughter previously seen a counselor? Yes/No If Yes, where:

Approximate Dates of Counseling:

For what reason did your child go to counseling?

Does your child have a previous mental health diagnosis?

What did you find most helpful in therapy?

What did you find least helpful in therapy?

Has your child used psychiatric services? Yes ___ No ___

If yes, who did they see?

If yes, was it helpful? N/A ___ Yes ___ No ___

Has your child taken medication for a mental health concern? Yes ___ No ___ Name of medication _____ Dates taken _____

Was it helpful? (Y/N)

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

CHEMICAL USE

Do you have any concerns with your child using alcohol or drugs? (Y/N) _____ If yes, please explain your concern: _____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your child 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. Please only answer if you feel comfortable doing so.

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? Please only answer if you feel comfortable to do so.

PARENT’S MARITAL STATUS (this question refers to the biological parents relationship)

Single, Married, Divorced, Cohabiting, Divorce in process, Separated, Widowed, Other _____

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.)

Biological Father’s Name: _____ Birth Date: _____ Age: _____ 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 bio-mother OR check here if you are still with bio-mother _____

Assessment of current relationship if applicable: Poor _____ Fair _____ Good _____

Biological Mother’s Name: _____ Birth Date: _____ Age: _____ 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 bio-father OR check here if you are still with bio-father _____

Assessment of current relationship if applicable: Poor _____ Fair _____ Good _____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

1. Fighting 2. Disagreeing about relatives 3. Feeling distant 4. Disagreeing about friends 5. Loss of fun 6. Alcohol use 7. Lack of honesty 8. Drug use 9. Physical fights 10. Infidelity (couple)
11. Education problems 12. Divorce/separation 13. Financial problems 14. Issues regarding remarriage 15. Death of a family member 16. Birth of a sibling 17. Abuse/neglect 18. Birth of a child 19. Inadequate housing 20. Feeling unsafe 21. Job change or job dissatisfaction

Other concerns not listed above _____

YOUR ADOLESCENT'S STRENGTHS

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

What personal qualities would you say your child has?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your child's life? (Please describe)

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR CHILD/ADOLESCENT

SYMPTOMS	None	Mild	Moderate	Severe	SYMPTOMS	None	Mild	Moderate	Severe
SADNESS					RACING THOUGHTS				
HEADACHES					LOW ENERGY				
APPETITE CHANGES					OBSESSIVE THOUGHTS				
WEIGHT CHANGES					UNPLANNED CHANGES				
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RESTLESSNESS					NIGHTMARES				
OTHER:					OTHER:				

Is there anything else you would like to share: _____
