TRUE LIVING
COUNSELLING & COACHING INC

Adolescent Intake Form

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Welcome to True Living Counselling and Coaching Inc. 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 do not want to answer at this time.

ADOLESCENT INTAKE FORM (ages 12-17) Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-8

CLIENT INFORMATION – Adolescent complete pages 1-3

Name:_____Date of Birth: _____ Age: _____

Name of Family Doctor: _____ Your Email: _____

Phone (Cell): _____Messages okay?_____

School: _____ Grade: _____

Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

_____

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? _____.

Do you currently Vape? _____Yes, _____No If yes, how often do you vape? _____

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 _____

FAMILY HISTORY

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

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

3. If your parents are divorced/seperated, 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. Inadequate housing 19. Feeling unsafe 20. Job change/loss

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 you 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. 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					NIGHTMARES				
CRYING					LONELINESS				
SUICIDAL THOUGHTS					GRIEF				
SLEEP DISTRUBANCES					PROBLEMS AT HOME				
PARANOID THOUGHTS					CUTTING/BURNING				
POOR CONCENTRATION					MOOD SWINGS				
BINGING/PURGING					HOPELESSNESS				
EXCESSIVE WORRRY					PHOBIAS				
PAST SUICIDE ATTEMPTS					ANGER				
ANOREXIA					IRRITABILITY				
FEELING ANXIOUS					GUILT				
PANIC ATTACKS					SOCIAL ISOLATION				
TRAUMA FLASHBACKS					SOCIAL ANXIETY				
WORK ISSUES					LOW SELF WORTH				
HYPERACTIVITY					EASILY DISTRACTED				

Is there anything else you would like to share: _____

Parent/Guardian Section

ADOLESCENT INTAKE FORM (PARENT SECTION p.4-8)

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: _____

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. _____

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 child previously seen a counselor? Yes/No If Yes, where:

_____

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 child 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 child 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, Cohabitating, 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: _____ Age: _____ Ethnic Origin: _____
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: _____ 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 CHILD/ADOLESCENT'S STRENGTHS

What activities do you feel your child 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				
CRYING					LONELINESS				
SUICIDAL THOUGHTS					GRIEF				
SLEEP DISTRUBANCES					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				

Is there anything else you would like to share: _____