Integrated Therapy Services

Teen Information Intake Form

Please answer the following as completely as possible. Use the back if additional space is needed.

Client Name: _____ Date: _____
(Last) (First) (Middle Initial)

Gender: F___ M___ Ethnicity:_____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (cell) _____ (work) _____
Ok to leave a message? YES / NO YES / NO YES / NO

In the event of an emergency contact: _____ Phone: _____

Emergency Contact person's relationship to you: _____

School:_____ Grade: _____

Occupation/Company: _____

Client Resides With:

_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*

Additional Family Members / Caregivers:

_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*
_____	_____	_____
Name	*Age*	*Relationship to Client*

Referred to this office by: _____

Physician's Name: _____ Phone:_____

Date last Seen: _____ Reason: _____

Medications: _____

Allergies: _____

Medical Issues/Surgeries/Accidents: _____

_____

Previous Counseling? Yes/No If yes, with whom: _____When:_____

Reason for previous counseling: _____

_____

Psychiatrist Name: _____ Phone: _____

Have you ever been hospitalized for mental health reasons? Yes/No

If yes, Where? _____ When? _____

Reason: _____

Did you reach developmental milestones at age appropriate times? Yes/No

If no, please explain: _____

Please describe any difficulties related to pregnancy/birth/postpartum: _____

_____

Circle any of the following that are supportive influences in your life:

Extended Family	Faith Based Support	Cultural or Ethnic Resources
Counselor/Doctor	Physical Therapy	Childcare
Employer	School	Other: _____
Friends	Community Resources	_____

Circle any of the following you have experienced or been involved with:

Physical Abuse	Emotional Abuse Sexual	Abuse	Traumatic Accident
Theft	Assault	Suicide Attempt	Death of a Loved One
Major Illness	Surgery	Disability	Separation
Miscarriage	Abortion	Homelessness	Incarceration
Drug Use	Eating Disorders	Gender Identity	Domestic violence

Other: _____

Are there any concerns with: (if yes, please explain)

Drug/Alcohol Use - Yes/No _____

Mental Health - Yes/No _____

Video Games/Internet Use - Yes/No _____

Parenting - Yes/No _____

Marital or Relationship(s) - Yes/No _____

Employment/Work- Yes/No _____

In the past 2 to 4 weeks have you noticed any of the following:

Hyperactivity	Aggression	Irritability	Feeling Anxious
Apathetic	Obsessions	Crying Spells	Sleeping Problems
Excessive Worry Fatigue	Depression	Memory Problems	Unfaithful to Spouse
Phobias	Lying	Weight Loss/Gain	Problems Concentrating
Restlessness	Feeling Conflicted	Nightmares	Other: _____

How would you rate your over all functioning? (circle one)

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Unable to function in all areas		Unable to function in most areas		Serious difficulty functioning		Mild to moderate difficulty		Minimal difficulty	No difficulty

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Please indicate if your child has experienced any of the following in the past 6 months:
(0= None; 1= mild; 2= moderate; 3= severe; 4= extreme; 5= very extreme)

	#		#
Relationship problems with siblings		Fears	
Problems with other children		Upset stomach	
Parent-child difficulties		Vomiting	
Death of someone close to child		Difficulty with bowel movements	
Nervousness		Weight problems (loss/gain)	
Moodiness		Eating problems	
Temper tantrums		Change in appetite	
Very Active		Fatigue	
Tension		Anxiety	
Easily upset		Sleep problems	
Crying		Encopretic (soiling self)	
Feels unhappy		Enuretic (wetting self)	
Lacks self-confidence		School problems	
Feels lonely		Poor speech/language skills	
Destructive behavior		Vision/ hearing difficulties	
Anger		Poor coordination	
Irritability		Discipline problems	
Easily distracted		Stealing	
Confusion		Sexualized behavior	
Obsessions		Aggression	
Phobias		Fidgety/Restlessness	
Nightmares		Excessive worry	
Depression		Boredom	
Memory problems		Fighting	
Lying/dishonesty		Problems Concentrating	
Other:		Other:	

To be completed by teen:

Are you concerned with any of the following:

Suicidal thoughts, plans, attempts? _____

Fear for your life or your safety? _____

Depression/Lack of care for self? _____

What are some of your strengths? What do you like about yourself? _____

_____

What do you do for fun? _____

_____

How many close friends do you have? Would you like this to be different in any way? _____

_____

What do you like most about school? What do you like least about school? _____

_____

Do you participate in any after school activities? _____

_____

Do you have a boyfriend/girlfriend? _____

Which social networking sites do you spend time using?

_____

_____

How many hours a day do you spend on your phone, computer, or electronic device? _____

Have you ever been on a 'diet' or wanted to lose or gain weight? _____

_____

Tell me about the role of drugs or alcohol in your life - _____

_____

When was the last time you used? _____

What did you use?

_____

_____

TREATMENT PLAN- Briefly state why you are seeking counseling. What do you hope to change?

Our goals for counseling are:

1.

2.

3.

Notes:

In signing below, I affirm that the information given is true and complete to my knowledge.

_____ _____

Client Signature ***Date***

_____ _____

Therapist Signature ***Date***