ADOLESCENT INTAKE FORM

Parent/Guardian - Please complete the below section:

Your Name: _____ Today's Date: _____

Address: _____

_____

Cell Phone: _____ May I leave a voice message? □ Yes □ No
May I leave a text message? □ Yes □ No
Home Phone: _____ May I leave a message? □ Yes □ No

Email Address: _____ May I email you? □ Yes □ No

How did you hear about Authentic Living? _____

Adolescent's: Name: _____ Nickname: _____

Adolescent's: Date of Birth: _____ Age: _____ Gender: _____

HOUSEHOLD INFORMATION

List those in the adolescent's primary household:

Name	Relationship to Adolescent	Gender	Age

Does the adolescent have more than one home? If yes, please provide the above details: _____

_____

Has the adolescent every been in a shelter, juvenile detention, or other placement? _____

If yes, where was the placement? _____

Has the adolescent had other legal involvements? (probation, child protection, first time offender, etc.) If yes, please describe: _____

_____

Please list any other health care professionals the adolescent is currently working with:_____

_____

Please list any medications the adolescent is currently taking: _____

_____

Has the adolescent seen a therapist or mental health professional in the past? □ Yes □ No
If yes, please describe briefly and provide dates:

_____

_____

Does the adolescent have a primary care doctor? □ Yes □ No

Name & Clinic: _____

Is the adolescent experiencing any current medical problems? □ Yes □ No

_____

Any past medical problems? □ Yes □ No

_____

The remaining pages are to be completed by the adolescent with assistance from parent/guardian and/or therapist as needed and as seems appropriate.

CURRENT SITUATION

Describe the concerns that led you or your parent(s) to seek therapy.

_____

_____

_____

Describe the things that you and your family have already done to try to deal with these concerns.

_____

_____

_____

Describe the things that you hope to accomplish and changes you would like to make in therapy.

_____

_____

_____

Name your strengths, areas of interest, things you do well and/or activities you enjoy.

_____

_____

_____

Do you have a best friend or friends? Do you like school? Do you participate in other activities (e.g. church, sports, arts, etc.)? Are there other important people in your life (not listed elsewhere)?

_____

_____

_____

Where do you go to school? _____

What grade are you in? _____ Do you have a job? _____ If yes, what do you do? _____

RISK CONCERNS

Have you ever felt like you don't want to be alive? □ Yes □ No
Do you feel that way now? □ Yes □ No

Have you, or do you ever, hurt yourself by doing any of the following?
____ pulling out your hair _____ cutting/stabbing ____ burning
____ driving while drinking _____ driving too fast ____ eating something you know will make you sick

Have you tried alcohol? □ Yes □ No
If so , what happen? _____
_____

Have you tried drugs? □ Yes □ No

If so, what drugs? _____

What happened? _____

_____

Do you still use sometimes? □ Yes □ No

Have you been in trouble because of using drugs or alcohol? □ Yes □ No
with: □ parents □ law □ peers □ other _____

Do you, or does anyone close to you, have concerns about your use of alcohol or drugs? □ Yes □ No

Do you have concerns about the substance use or abuse of anyone close to you? □ Yes □ No

If so, whom? _____ □ Currently □ Past

Have you ever had any treatment for substance abuse? □ Yes □ No

If so, where? _____ When? _____

Are you having trouble sleeping? _____ □ Yes □ No

_____

ADDITIONAL INFORMATION

How often do you engage in physical activity and what do you do? _____

_____

How do you describe your racial, ethnic, or cultural background?_____

_____

Do you have a religious community or spiritual practices that are important to you? _____

_____

What are effective coping strategies that you've learned? _____

_____

Is there anything else you'd like me to know? (Use the back for more space) _____

_____