Prema Health
Our Inner Landscape
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Individual & Couples Counseling
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ADOLESCENT INTAKE FORM

CLIENT INFORMATION

Name: _____
Date of Birth: _____ Age: _____
Gender:_____ Phone (Cell): _____Messages okay?___ Text reminder 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 counseling? _____
_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor?❒Yes❒No 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 substances? _____Yes, _____No If yes, please describe?
_____ If yes, how often?
_____Daily, _____Weekly, _____Occasionally, _____Rarely

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 check any family concerns that your family is currently experiencing*)

fighting
Disagreeing about relatives
feeling distant
Disagreeing about friends
Loss of fun
Alcohol use
Lack of honesty
Drug use
Physical fights
Infidelity (couple)
Education problems
Divorce/separation
Financial problems
Issues regarding remarriage
Death of a family member
Birth of a sibling
Abuse/neglect
Birth of a child
Inadequate housing/feeling unsafe
Inadequate health insurance
Job change or job dissatisfaction
Other

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

Do you like school? (Y/N)_____ Do you attend regularly? (Y/N)_____ What are your current grades? _____ Do you feel you are doing the best you can at School? (Y/N)
_____

INDIVIDUAL CONCERNS

SYMPTOM

SADNESS
SLEEP DISTRUBANCES
PROBLEMS AT HOME
HYPERACTIVITY
BINGING/PURGING
LONELINESS
UNRESOLVED GUILT
IRRITABILITY
NAUSEA/INDIGESTION
SOCIAL ANXIETY
SELF HARM/ CUTTING
IMPULSIVITY
NIGHTMARES
HOPELESSNESS
ELEVATED MOOD
MOOD SWINGS
DISORGANIZED
ANOREXIA
GRIEF
PHOBIAS HEADACHES
WEIGHT CHANGES
APPETITE CHANGES
SOCIAL ISOLATION
PARANOID THOUGHTS
POOR CONCENTRATION
INDECISIVENESS
LOW ENERGY
EXCESSIVE WORRY
LOW SELF WORTH
ANGER ISSUES
SPIRITUAL CONCERNS
HALLUCINATIONS
RACING THOUGHTS
RESTLESSNESS
DRUG USE ALCOHOL USE
EASILY DISTRACTED
TRAUMA FLASHBACKS
OBSESSIVE THOUGHTS
PANIC ATTACKS
FEELING ANXIOUS
FEELING PANICKY
SUICIDAL THOUGHTS
PAST SUICIDE ATTEMPTS
OTHER