Prema Health
Our Inner Landscape
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Individual & Couples Counseling
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ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: ____ Date of Birth: ______________________________ Age: ____________ Gender __________

Race/Ethnic Origin: ____

Religious/ Spiritual Preference: ____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

(If additional space is need please list on the back of page)

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?

____
____
____
____

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

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

Please continue on the back or add an additional sheet for any other significant family members

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:
____

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 son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?
____ If yes, was it helpful? N/A____ Yes____ No______
Has your son or daughter taken medication for a mental health concern? Yes______ No _________
If yes, 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 son or daughter using alcohol or other drugs? (Y/N) _________
If yes, please explain your concern:
____
____
____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter 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, at present, or have had a significant effect upon you or your child in the past. ____
____
____

FAMILY HISTORY

Are you aware or concerned of of any trauma your child might have experienced?
____
____
____
____

Did either parent experience any abuse as a child in their home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.
____
____
____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?
____
____
____

PARENT'S MARITAL STATUS *(this question refers to the biological parents relationship)*
❒Single ❒Married (legally) ❒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: ____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 ifyou are no longer with your child's bio-father OR check here ifyou 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.
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

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 son or daughter has?
____
____
____

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

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR CHILD

SYMPTOMS

SADNESS
SLEEP DISTRUBANCES
DISSOCIATION
HYPERACTIVITY
BINGING/PURGING
UNRESOLVED GUILT
IRRITABILITY
NAUSEA/ INDIGESTION
SOCIAL ANXIETY
SELF HARM/ CUTTING
IMPULSIVITY
NIGHTMARES
HOPELESSNESS
ELEVATED MOOD
MOOD SWINGS
DISORGANIZED
ANOREXIA
SOCIAL ISOLATION

PHOBIAS
OBSESSIVE THOUGHTS
GRIEF
HEADACHES
LONELINESS
APPETITE CHANGES
WEIGHT CHANGES
PARANOID THOUGHTS
POOR CONCENTRATION
INDECISIVENESS
LOW ENERGY
EXCESSIVE WORRRY
LOW SELF WORTH
ANGER ISSUES
SPIRITUAL CONCERNS
HALLUCINATIONS
RACING THOUGHTS
RESTLESSNESS
DRUG/ALCOHOL USE
DECREASED CREATIVITY
EASILY DISTRACTED
TRAUMA FLASHBACKS
WORK/SCHOOL ISSUES
PROBLEMS AT HOME
PANIC ATTACKS
FEELING ANXIOUS
FEELING PANICKY
SUICIDAL THOUGHTS
PAST SUICIDE ATTEMPTS
OTHER

Is there anything else you would like to share:

____

____

____

____

____

Special Confidentiality Notice for Parents

Providing services to children and adolescents may present special challenges in relation to consent to treatment and confidentiality.

By Oregon Law, the custodial parent or guardian is the only person who can provide consent for treatment for children under 14 years old. Please note that a noncustodial parent is only legally able to provide consent for treatment in the case of emergencies when the custodial party is not available. Both custodial parents/guardians and noncustodial parents have the same rights regarding access to treatment information such as discussing treatment with me or reviewing treatment records directly pertaining to the identified client. This does not include access to information about others who may be referred to in the records during the course of treatment such as other parents, family members, etc.

It is always my goal to increase connection and communication between youth and their parents whenever possible. However, establishing a trusting relationship with a child or adolescent client may require me to sometimes keep some information shared in therapy confidential from parents.

Please note, any information that includes threat of harm to a child/adolescent or other will be shared with parents except when to do so would put a child/adolescent in harm's way. Always, I encourage parents to share any information or concerns with me about the child/adolescent that would be helpful in understanding them or their treatment needs. Similarly, parents are always welcome and encouraged to present me with any questions or concerns about the therapy process for discussion and shared decision-making.