Client Intake Form

Adolescent/Teen History

Client's Name: _____ Age: _____ Date: _____

Person completing form: _____ Relationship to child: _____

Who has legal custody of the child: _____

School: _____ Grade: _____

Briefly describe the reason you brought your child to counseling: _____

_____

_____

Has your child received psychiatric or psychological treatment or counseling before? YES NO

Check all of the symptoms your child is experiencing:

- ☐ Abuses alcohol/drugs
- ☐ Afraid to be alone
- ☐ Arguing excessively
- ☐ Avoids certain people/places
- ☐ Change in eating habits
- ☐ Cries a lot
- ☐ Depression
- ☐ Difficulty concentrating/focusing
- ☐ Difficulty sleeping
- ☐ Dislike for self
- ☐ Doesn't trust others
- ☐ Engages in risky behavior
- ☐ Fascinated with fire
- ☐ Frequent irritability
- ☐ Has unusual mannerisms
- ☐ Headaches/migraines
- ☐ Hurts self on purpose
- ☐ Increased aggression
- ☐ Lies
- ☐ Little sense of joy or happiness
- ☐ Moodiness
- ☐ Nightmares
- ☐ Poor peer relationships
- ☐ Running Away
- ☐ School suspension
- ☐ Shows little emotion
- ☐ Steals
- ☐ Stomachaches
- ☐ Talks about or has attempted suicide
- ☐ Unusually clingy
- ☐ Wets the bed
- ☐ Other: _____

Are you aware of any event(s) that may have caused these problems? _____

_____

_____

Who is living in the home?

Name	Age	Relationship to the child	School/Occupation

List other persons closely involved with your child but not living in the home: _____

_____

_____

Briefly describe your relationship with your child: _____

_____

_____

Briefly describe how your child gets along with other family members: _____

_____

_____

Is there a family history of mental health concerns? If yes, please describe:_____
_____
_____

Please check all that apply to your family:

- ☐ Alcoholism/Drug Use
- ☐ Death in Family
- ☐ Health Concerns
- ☐ Job Loss
- ☐ Marital Difficulties
- ☐ Mental Illness
- ☐ Physical/Sexual/Emotional Abuse
- ☐ Other:_____
  _____

How is your child disciplined and by whom? _____
_____
_____

Health Information:

List any major health problems for which your child currently receives treatment: _____
_____
_____

Medication	Dose	Frequency	Purpose

Academic Information:

Briefly describe how your child is functioning at school (academically, socially, behaviorally):_____
_____
_____

Does your child have difficulty making or keeping friends? YES NO

What activities is your child currently involved in after school: _____
_____

Other Information:

What are your child's strengths and interests? _____
_____
_____

Parent's Goals for Therapy

1. _____
2. _____
3. _____
4. _____