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Child/Adolescent Intake Information

Date_____

Name_____

Address City State Zip_____

Home Phone:_____ Is it all right to call you at these numbers? Yes No

Date of Birth_____ Ethnicity_____

Name Parent or Legal Guardian _____

Address_____ City_____ _____State_____
Zip_____

Home Phone: _____Work Phone: _____Cell Phone:_____

Referred by:_____

Previously in counseling Yes? No

For?_____

Problems or concerns you would like to talk
about_____
_____
_____
__

Client's view of how s/he rates the problem at intake:

1 2 3 4 5 6 7 8 9 10

Not Bad at All _____Very Bad

Are you currently experiencing any of the following?

Significant weight gain/loss Problems/concerns with family Self-esteem concerns

Problems sleeping Problems/concerns with friends Financial concerns

Nervousness or anxiety Death of family member/friend Transition concerns

Problems with job Divorce Stress

Legal concerns School/classroom concerns Time Management

Any physical problems? Yes/ No If yes, please describe:_____
_____

Have you had to stay in a hospital recently? Yes/ No

If yes, when?_____

Are you currently on any medications? Yes/ No

What medication?_____

For what condition?

Do you currently have, or have you ever had, drug/alcohol problems? Yes /No_____
_____

Are you having thoughts of hurting yourself? Yes/ No

Hurting others? Yes /No

For Counselor Use Only