Clinical Intake Form for Teens

Client Contact Information

First Name: ___________________ Last Name: ______________________________

Today's Date: ____________ Age: ___________ Gender: _____________

Date of Birth: ____________ Place of Birth: ____________________________

Where do you live?

____

Have you always lived there?

____

Who lives with you?

____

Does everyone at home get along?

____

Whose idea was it for you to come to therapy?

____

Goals you want to accomplish in therapy:

____

____

In the last few years, have you experienced any significant life changes or stressors (deaths, moves, accidents, health issues, family or school issues, etc.)? If so, please describe:

____

____

For each one, circle Yes or No regarding the past few weeks:

Are you often stressed? Yes No

Are you often sad? Yes No

Are you often worried or anxious? Yes No

Are you often angry? Yes No

What makes you feel better when you are feeling badly?

____

Do you have pets? Yes No Name and type:

____

Do you have a job?

____

School Information and History

What grade are you in and where do you go to school?

____

Do you like school? If not, why?

____

Do you struggle with the academic part of school?

____

What are your favorite classes?

____

What are your least favorite classes?

____

Do you have any issues with other kids or the social part of school? If so, please describe:

Please name some of your closest friends:

Are you involved in a romantic relationship? Yes No
Do you struggle with issues of gender identity or sexual orientation? Yes No

What extracurricular activities are you involved in?

Medical Information and History

Please list any **current** medical problems (headaches, stomach aches, illnesses, etc.):

Please list any significant medical history with dates (hospitalizations, accidents, surgeries, etc.):

Do you have allergies to anything (medications, food, etc.)?
____

____

Is it easy for you to get to sleep? _____________
Do you wake up a lot at night? ______________
Do you have nightmares? _________________

Do you have a history of eating problems or are you currently struggling with food and/or weight issues? ____

How frequently do you exercise? ____

Mental Health Treatment History

Have you been in therapy before? Yes No

If yes, when and for how long?
____

Previous therapist(s) name(s): ____

Reasons for previous therapy:____

Have you had a crisis assessment or been hospitalized for mental health reasons? If so, when?
____
Do you ***currently*** feel hopeless or have suicidal thoughts? _______________________
In the past?____
Are you now or have you in the past engaged in self-harming behaviors?____________
If so, when? ____
Have you experienced trauma (abuse, accidents, etc.)? __________________________

Have you ever taken medication for mental health reasons?
____

____

Current Substance Use History and Frequency (Circle):

Alcohol:	Daily	Weekly	Monthly
Cigarettes:	Daily	Weekly	Monthly
Marijuana:	Daily	Weekly	Monthly
Other:	Daily	Weekly	Monthly

None (circle if not applicable)

Please list any ***prior*** substance use (alcohol, cigarettes, marijuana, etc.):

____

____

Are you now or have you previously been a member of a substance abuse program or support group (circle one)? Yes No

Have you previously been treated for substance abuse (circle one)? Yes No

Legal

Is your family currently involved in a divorce and/or custody situation? Yes No

Have you ever been arrested? Yes No

If yes, please describe charges and outcome, including dates:

____

Do you currently have an assigned probation officer *and/or* social worker? Yes No

If yes, who: ____

Other

What are your hobbies, interests, and strengths?

____

____

____

____

What are the areas you would like to improve as a result of therapy?

____

____

____

____

Please list any information not listed on this form that you feel I should know about you:

____

____

____

____