Adolescent/Parent Intake Questionnaire

Your response to the following questions will enable your therapist to better understand you and your situation. Please answer all questions as completely as you can. Adolescent please fill out pgs 1-3, parent/guardian pgs 4-8.

**Adolescent section (ages 12-17)**

Name:____________________________Preferred Name:________________________________

Birthdate:___________________________ Age:_______ Gender:_________________________

Phone (Cell):__________________ Messages okay? ☐ Yes ☐ No Text Reminders? ☐ Yes ☐ No

School Name: ____________________________________________ Grade:_________________

Please share which electronic communications (Facebook, Twitter, Snapchat, Instagram, etc.) that you use:

_________________________________________________________________

Do your parents have access to your electronic communications? ☐ Yes ☐ No

Do they have issues with your use of phone, text, or electronic communications? ☐ Yes ☐No

## Personal Strengths:

What activities do you enjoy and feel you are successful when you try? ___________________

____________________________________________________________________________________

Name some positive aspects of your life such as, influential people and supportive people, uplifting activities (e.g. walking), or beliefs (religion) in your life? (Please describe)

____________________________________________________________________________________

____________________________________________________________________________________

## Current Reason for Seeking Counseling:

Please briefly describe the problem for which you are seeking to have counseling: __________

____________________________________________________________________________________

____________________________________________________________________________________

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? _______________________________________

____________________________________________________________________________________

Is there anything about you that you wish people could understand? ______________________

____________________________________________________________________________________

## Chemical Use and History:

Do you currently use alcohol? ☐ Yes ☐ No  If yes, how much do you drink? ___ (#) per time

If yes, how often do you drink?  ____ Daily ____ Weekly ____ Occasionally ___ Rarely

Do you currently use tobacco? ☐ Yes ☐ No  If yes, how much do you smoke/chew? _______

If yes, how often do you smoke/chew?  ___ Daily ___ Weekly ___ Occasionally ___ Rarely

Do you currently use any other drugs? ☐ Yes ☐ No  If yes, what do you use? ____________

If yes, how often do you use?  ____ Daily ____ Weekly ____ Occasionally ___ Rarely

Have you received any previous treatment for chemical use? ☐ Yes ☐ No

If so, where did you go? _________________________________ ☐ Inpatient ☐ Outpatient

Have you ever used more than one chemical at the same time to get high? ☐ Yes ☐ No

Do you avoid family activities so you can use? ☐ Yes ☐ No

Do you have a group of friends who use also? ☐ Yes ☐ No

Do you use to improve your emotions such as when you feel sad or depressed? ☐ Yes ☐ No

## 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:

Are your parents married, seperated, or divorced? __________________________________

Do you think their relationship is good?  _____ Yes _____ No ____ Unsure

If your parents are divorced, who do you live with? _________________________________

How often do you see each parent?  ______% Mom  _____% Dad

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 | | Infidelity (couple) |
| | Physical fights | | Divorce/separation |

|  | Education problems |  | Issues regarding remarriage |
|---|---|---|---|
|  | Financial problems |  | Birth of a sibling |
|  | Death of a family member |  | Birth of a child |
|  | Abuse/neglect |  | Inadequate health insurance |
|  | Inadequate housing/feeling unsafe |  | Drug use |
|  | Job change or job dissatisfaction |  | Other |

Other concerns not listed:

_______________________________________________________________________________

## School History:

Do you like school? ☐ Yes ☐ No Do you attend regularly? ☐ Yes ☐ No

What are your current grades? ___________________________________________________

How would you describe your current efforts in school? ______________________________

## Individual Concerns:

| **Symptoms** | **0** | **1** | **2** | **3** | **Symptoms** | **0** | **1** | **2** | **3** |
|---|---|---|---|---|---|---|---|---|---|
| Sadness |  |  |  |  | Appetite Changes |  |  |  |  |
| Crying |  |  |  |  | Social Isolation |  |  |  |  |
| Sleep Disturbances |  |  |  |  | Paranoid Thoughts |  |  |  |  |
| Problems at home |  |  |  |  | Poor Concentration |  |  |  |  |
| Hyperactivity |  |  |  |  | Indecisiveness |  |  |  |  |
| Binging/Purging |  |  |  |  | Low Energy |  |  |  |  |
| Loneliness |  |  |  |  | Excessive Worry |  |  |  |  |
| Unresolved Guilt |  |  |  |  | Low Self-Worth |  |  |  |  |
| Irritability |  |  |  |  | Anger Issues |  |  |  |  |
| Nausea/Indigestion |  |  |  |  | Spiritual Concerns |  |  |  |  |
| Social Anxiety |  |  |  |  | Hallucinations |  |  |  |  |
| Self-Mutilation |  |  |  |  | Racing Thoughts |  |  |  |  |
| Cutting |  |  |  |  | Restlessness |  |  |  |  |

| Impulsivity | | | | | Drug Use | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Nightmares | | | | | Alcohol Use | | | | |
| Hopelessness | | | | | Easily Distracted | | | | |
| Elevated Mood | | | | | Trauma Flashbacks | | | | |
| Mood Swings | | | | | Obsessive Thoughts | | | | |
| Disorganized | | | | | Panic Attacks | | | | |
| Anorexia | | | | | Feeling Anxious | | | | |
| Grief | | | | | Feeling Panicky | | | | |
| Phobias | | | | | Suicidal Thoughts | | | | |
| Headaches | | | | | Past Suicide Attempts | | | | |
| Weight Changes (unplanned | | | | | Other: | | | | |

## Peer Relations:

How do you consider yourself socially? ☐ Outgoing ☐ Shy ☐ Depends on the situation

Are you happy with the number of friends you have? ☐ Yes ☐ No

Have you ever been bullied? ☐ Yes ☐ No

Are you involved in any organized social activities? (Scouts, sports, music, etc) ____________

______________________________________________________________________________

**Adolescent Intake Form**
(Parent/Guardian Section)

Adolescent's name:___________________ Parent's/Guardian's name:__________________

Race/ethnic origin:___________________ Religious preference:_______________________

## Current Household and Family Information:

| Name | Relationship (Parent, sib) | Age | Gender | Type (Bio, Step, etc.) | Living with you? y/n |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

(If additional space is needed, please list on 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? _____________________________________________

____________________________________________________________________________

## Child Development

Were there any complications with the pregnancy or delivery of your child? ☐ Yes ☐ No

If yes, please describe: _________________________________________________________

Did your child have health problems at birth? ☐ Yes ☐ No If yes, please describe:

____________________________________________________________________________

Did your child have any developmental delays? (i.e. walking, talking) ☐ Yes ☐ No

If yes, please describe:__________________________________________________________

Did your child have any unusual behaviors or problems prior to the age of 3? ☐ Yes ☐ No

If yes, please describe: ___________________________________________________________

Has your child experienced an emotional, physical, or sexual abuse?☐ Yes ☐ No ☐ Not Sure

If yes, please describe: ___________________________________________________________

## Counseling History:

Has your son/daughter previously seen a counselor? ☐ Yes ☐ No

If yes, where? ___________________________________________________________________

Approximate dates of counseling: ____________________________________________________

Does your son/daughter have a previous mental health diagnosis? ☐ Yes ☐ No

What did you find **most** helpful in therapy?___________________________________________

_________________________________________________________________________________

What did you find **least** helpful in therapy?___________________________________________

_________________________________________________________________________________

Has your son/daughter used psychiatric services? ☐ Yes ☐ No With whom?______________

If yes, was it helpful? ☐ Yes ☐ No

Does your son/daughter have other medical concerns or previous hospitalizations?☐ Yes ☐ No If so, please describe: _______________________________________________________

## Chemical Use:

Do you have any concerns with your son/daughter using alcohol or drugs? ☐ Yes ☐ No

If yes, please explain concern: _____________________________________________________

## Internet/Electronic Communications Usage:

Do you have any concerns with your son/daughter using the internet or electronic communications such as Facebook, Snapchat, Twitter, texting, etc? ☐ Yes ☐ No
If yes, please explain concern: _____________________________________________________

## Legal Issues:

Please list any legal issues that are affecting you or your family, son/daughter, at present, or have had a significant effect upon you or your son/daughter in the past.

_________________________________________________________________________________

_________________________________________________________________________________

## Family History:

Are you aware of any birth trauma your son/daughter experienced from 0-3?

_________________________________________________________________________________

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.

_________________________________________________________________________________

Have you experienced any abuse as an adult? ________________________________________

________________________________________________________________________________

## Parent's Marital Status *(This question refers to biological parents' relationship)*

☐ Single ☐ Married(legally) ☐ Divorced ☐ Cohabitating ☐ Divorce in process ☐ Separated
☐ Widowed ☐ Other

Length of marriage/relationship: ______ How old was your child at the time of divorce? ____

If divorced, how much does your child spend with each parent? ____% Mother ____% Father

*(Please answer all the following the best you can, we understand you may not be able to answer some of the questions pertaining to the other parent)*

**Biological Father's Name:___________________________________**_Age:_____________

Ethnic Origin:__________________________________________________________________

Total years of education completed:______ Occupations:______________________________

Place of employment:____________________________________________________________

Military Experience: ☐ Yes ☐ No Combat Experience: ☐ Yes ☐ No

*Current Status:
☐ Single ☐ Married(legally) ☐ Divorced ☐ Cohabitating ☐ Divorce in process ☐ 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:___________________________________**_Age:____________

Ethnic Origin:__________________________________________________________________

Total years of education completed:______ Occupations:______________________________

Place of employment:____________________________________________________________

Military Experience: ☐ Yes ☐ No Combat Experience: ☐ Yes ☐ No

*Current Status:
☐ Single ☐ Married(legally) ☐ Divorced ☐ Cohabitating ☐ Divorce in process ☐ Separated
☐ Widowed ☐ Other *Please answer if you are no longer with your child's bio-father or check here if you are still with bio-father___

Assessment of current relationship if applicable: ____Poor ____Fair ____Good

## Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to **Wisconsin law**, and the federal patient privacy law known as **HIPAA**, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.
- You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.
- In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.
- Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you.

If you would like more information regarding your adolescent's treatment rights in the state of Wisconsin please ask for a brochure if you have not already received one.

Please sign and date to confirm that you have received and read this statement.

| | |
|---|---|
| Signature | Date |