

Adolescent Minor Intake Form

Date of First Appointment: _____ Age _____

Name: _____

Address

City State Zip Code

Race/Ethnicity: African American _____ Asian _____ Caucasian _____ Latin _____
Native American _____ Other _____

What grade are you currently in? _____

Please list the grades received on your last report card or your current GPA:

What types of extracurricular activities are you involved in? _____

Are you currently employed? _____ Employer: _____

Briefly describe your reason for seeking counseling: _____

What goals do you hope to achieve by attending counseling? _____

Current hobbies/ personal interests: _____

Current religious/spiritual beliefs: _____

Please answer the following as it applies to you:

Do you currently have a license to drive? _____

Are you currently sexually active? _____

Do you currently feel pressure from peers to do things you don't want to do?

Please answer the following as it applies to you:

Do you currently have a license to drive? _____

Are you currently sexually active? _____

Do you currently feel pressure from peers to do things you don't want to do?

Are you now or have you ever been bullied at school?_____

Are you currently or have you in the past been involved in any gang/criminal activity?_____

Do you currently drink alcohol and if so please state the amount consumed per day/week? _____

Do you currently smoke and if so please state the amount consumed per day/week?_____

Do you currently use any controlled substances and if so please state the amount consumed per day/week?_____

How many times per week does your family sit down for meals together?

Have you ever previously attended therapy or received counseling services of any kind? Yes____ No_____ If yes please list the type of therapy you received_____

Did you find treatment helpful?_____

Previous therapist: _____

Previous Psychiatric Hospitalizations? _____

Treatment and Diagnosis Rendered?_____

Have you ever struggled with any of the following symptoms/behaviors? If so, please list when:

Anorexia/Bulimia

Drugs/ Alcohol

Fighting

Cutting

Suicidal thoughts/attempts

Homicidal thoughts

Running away

Truancy

Depression

Anxiety

Gang/criminal activity

Current height_____ Current weight_____

Are you currently involved in an exercise regimen?

Yes ___ No ___ If yes please list the type of exercise and amount per week

Pediatrician: _____ Phone # _____

When were you last examined by a physician? _____

List any major health problem for which you currently receive treatment:

Please list any medications you are currently taking:

Medication	Dosage	Treatment of Symptoms	Prescribing physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____