This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-7.

ADOLESCENT INTAKE FORM (ages 12-17)

CLIENT INFORMATION

Name:_____
Date of Birth: _____ Age: _____ ❒ Male ❒ Female
Physical Address: _____
Mailing Address: _____
Phone (Cell): _____ Messages okay?_____
Phone (Home): _____ Messages okay?_____
School: _____ Grade: _____
Race/Ethnic Origin: _____
Religious Preference: _____

PERSONAL STRENGTHS

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

_____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

_____
_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking 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? _____
_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes _____No
If yes, how often do you drink? _____Daily _____Weekly _____Occasionally _____Rarely
If yes, how much do you drink? _____(#) per time.
Do you currently use Tobacco? _____Yes _____No
If yes, how much do you smoke/chew? _____
Do you currently use any other drugs? _____Yes _____No
If yes, what drugs do you use? _____
If yes, how often do you use? _____Daily _____Weekly _____Occasionally _____Rarely
Have you received any previous treatment for chemical use? Y/N _____
If so, where did you go?_____
____Inpatient ____Outpatient

ADOLESCENTS (*please answer the following with* Y/N)

Have you ever used more than 1 chemical at the same time to get high? _____
Do you avoid family activities so you can use? _____
Do you have a group of friends who also use? _____
Do you use to improve your emotions such as when you feel sad or depressed?? _____

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 or divorced? _____
Do you think their relationship is good? (Y/N/Unsure)_____
If your parents are divorced, whom do you primarily 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 or Drug use
Lack of honesty	Trauma
Medical Concerns	Infidelity (couple)
Education problems	Divorce/separation
Financial problems	Issues regarding remarriage
Death of a family member	Birth of a child
Inadequate health insurance	Job change or job dissatisfaction
Inadequate housing/feeling unsafe	Other

Other concerns not listed above _____

PEER RELATIONS

How do you consider yourself socially: ___outgoing ____shy ____depends on the situation. Are you happy with the amount of friends you have? (Y/N)_____
Have you ever been bullied? (Y/N) _____

Are your parents happy with your friends? (Y/N)_____
Are involved in any organized social activities (e.g. sports, scouts, music)?
_____

SCHOOL HISTORY

Do you like school? (Y/N)_____
Do you attend regularly? (Y/N)_____
What are your current grades? _____
Do you feel you are doing the best you can at school? (Y/N) _____

Is there anything else you would like me to know: _____
_____
_____

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____Date of Birth: _____
Mother's/Guardian's Name: _____ Phone Contact:_____
Mother's/Guardian's Physical Address: _____
Mother's/Guardian's Mailing Address: _____
Father's/Guardian's Name: _____ Phone Contact:_____
Father's/Guardian's Physical Address: _____
Father's/Guardian's Mailing Address: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please list on the 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?
_____
_____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor?❒Yes❒No
If Yes, where: _____

April Blair, M.A. M.F.T. #113278
15300 Ventura Boulevard, Suite 328
Sherman Oaks, California

Approximate Dates of Counseling: _____
For what reason did your son or daughter go to counseling?

_____

_____

Does your son or daughter have a previous mental health diagnosis? _____
What did you find **most helpful** in therapy?

_____

_____

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

_____

_____

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?

_____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____
Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe: _____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?
Yes ___ No ___ If yes, describe:

_____

_____

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

_____

_____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ___ No ___ Not sure_____ If yes, describe:

_____

_____

Did your child have any unusual behaviors or problems prior to age 3?
Yes ___ No ___ Not sure_____ If yes, describe:

_____

_____

Has your child experienced emotional, physical, or sexual abuse?
Yes ____ No ____ Not sure _____ If yes, describe:

_____

_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____
If yes, please explain your concern:

_____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____
If yes, please explain your concern:
_____
_____

LEGAL ISSUES

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

FAMILY HISTORY

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)
Father's Name: _____Birth Date:_____ Age: _____
Ethnic Origin: _____
Total years of education completed: _____ Occupation: _____
Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____
Mother's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____
Total years of education completed: _____ Occupation: _____
Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

PARENT'S MARITAL STATUS

❒Single❒Married (legally)❒Divorced❒Cohabitating❒Divorce in process❒Separated
❒Widowed❒Other _____
Length of marriage/relationship:_____
If divorced, how old was your child at time of divorce? _____
If divorced, How much time does your child spend with each parent?
Mother_____%, Father _____%

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 or Drug use
Lack of honesty	Trauma
Medical Concerns	Infidelity (couple)
Education problems	Divorce/separation
Financial problems	Issues regarding remarriage
Death of a family member	Birth of a child
Inadequate health insurance	Job change or job dissatisfaction
Inadequate housing/feeling unsafe	Other

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____

_____

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

_____

_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____

_____

What personal qualities would you say your son or daughter has?

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

_____

Is there anything else you would like me to know: _____

_____

_____