



Adolescent Intake Form

Please answer all questions. Use the back for additional information if necessary. You will have a chance to explain any answers during our intake session.

Name: _____ Today's date: _____

Nickname/Name you want to be called: _____

Home Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell: _____

Other Phone: _____ Email: _____

Birth Date: _____ Age: _____

Identified Gender & Preferred Pronouns: _____ Biological Sex: _____

School: _____ Grade: _____

Is it OK to send confidential information to your e-mail address? Yes No

Is it OK to communicate through texting? Yes No

Is it OK to leave a voicemail? Yes No

With whom do you currently live? (Check Which Apply)

BOTH Parents/Legal Guardians ONE Parent/Legal Guardian

Other Family Members/Friends, List:

Parents'/Legal Guardian's Name: _____

Parents'/Legal Guardian's Phone & Email: _____

Are you currently employed? Yes No

IF yes, where? _____



Religious/Spiritual Affiliation (If Applicable): _____

Did you participate in the decision to start counseling? Yes No

HAVE YOU EVER HAD THOUGHTS OF WANTING TO HURT OR KILL YOURSELF? Y or N

If yes, please answer the following questions:

Are you feeling like you want to hurt or kill yourself right now? Y or N

When was the last time you thought about hurting or killing yourself? _____

Do you have a plan? Y or N

HAVE YOU EVER HAD THOUGHTS OF WANTING TO HURT OR KILL ANYONE ELSE? Y or N

If yes, please answer the following questions:

Are you feeling like you want to hurt or kill anyone right now? Y or N

When was the last time you thought about hurting or killing someone? _____

Do you have a plan? Y or N

IS THERE A KNOWN FAMILY HISTORY OF ANY OF THE FOLLOWING? (Circle all that apply)

- Sexual abuse* *Physical abuse* *Emotional abuse* *Rape* *Alcoholism/drugs*
- Violence* *Sleep disorders* *Eating disorder* *Physical conditions* *Mental health history*

IN THE PAST YEAR HAVE YOU EXPERIENCED DIFFICULTIES IN ANY OF THE FOLLOWING AREAS? (Circle all that apply)

- Marriage/partner* *Family* *Job/School* *Health* *Finances* *Friendships* *Legal* *Mood*
- Anxiety* *Eating habits* *Spirituality* *Anger* *Alcohol* *Drug(s)* *Sexual* *Caffeine*
- Smoking* *Aggression* *Impulsiveness* *Depression* *Loneliness* *Hopelessness* *Life Transitions* *Grief/Loss*

Previous History

Please describe what brings you to counseling currently.

What do you hope to gain through counseling?



What have you already done to deal with the difficulties?

Have you had previous psychological counseling or psychiatric help? Please check all that apply.

Individual counseling? If yes, when and where?

Group/Family Counseling? If yes, when/where?

Hospitalization(s)? If yes, when/where?

List any medications and dosages that pertain to your mental well-being:

List any other medications and dosages you currently take:

List any significant health problems for which you have been treated in the past and then place a check by those problems for which you are currently being treated:



List any serious or chronic illness, operations, or traumatic accidents you have had:

Are you currently, or have you at any time within the last 12 months been under the care of a physician? Yes No

If so, for what condition?

Who is your doctor? _____

Would you like me to speak with your doctor? Yes No

If yes, please fill out an ROI if you are 15 years or older or have your guardian sign an ROI.

What are your biggest strengths?

Do you exercise? Yes No

If yes, for how long and how many times per week?

Do you smoke? Yes No
If yes, what do you smoke? _____
How often? _____



Do you consume alcohol? Yes No

If yes, how often? _____

Do you take any non-prescribed (recreational) drugs? Yes No

If yes, what and how often? _____

Interactions between client and counselor are confidential. Unless I have permission from you, what we talk about will be private; I will not discuss it with anyone else. Our discussion will be private and confidential, even if you don't mind your parents knowing about anything that we talk about. There are four major exceptions to confidentiality that Colorado law requires all mental health professionals to report when there exists:

1. Incidence(s) of child or elder abuse or neglect.
2. Intent to commit suicide.
3. Threats to do harm to yourself or another person.
4. Court order.

Client's (signature): _____ Date: _____

IF you are **under** the age of 15 years old, must provide guardian's consent for mental health services.

Parent(s)/Guardian(s): _____ Date: _____

Counselor's (signature): _____ Date: _____