625 Jenks Avenue Panama City, Florida 32401 * Office 850-215-5657*FrontDesk@PanamaCityWellness.Com

****This professional relationship does not begin until the Intake session where the forms are then reviewed, agreed upon, and the consent form is signed by the therapist and those involved. If this is an emergency prior to the initial session, please contact 911.**

ADOLESCENT INTAKE FORM (ages 12-17)

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. **Parent/guardian**, please fill out what you can on pages 1, 2-4, **Adolescent** please fill out pages 1, 5-9.

Name: ______________________________________

Would like to be called: ________________________

E-Mail address: _______________________________

Social Security Number: ________________________

Email Address: _________________________________

Address: ______________________________________

____

____

School: _____________________________Grade: __________

Hobbies/Clubs: _______________________________________

____

Religious Beliefs: _____________________________________

Today's Date: __________ Gender M__ F__

Date of Birth: ____/_____/_____ Race/Ethnicity _______

Month Day Year

Who referred you to this office? _________________

Is Leaving Messages on personal numbers if needed okay? ____

Home Phone (____) __________________

Cell Phone (____) __________________

Parent's Cell (____) __________________

Employer: ___________________________

Phone #: ____________________________

GW Counselor: _______________________

Desired Counseling Mode: ___Ind ___Grp ___Fam

INSURANCE INFORMATION

Insurance Co: _________________________________ Policy #: _________________________________

Are you the Child's policy holder? Yes or No Policy Holder's Name: ______________________________________

Policy Holder's Date of Birth: _______________ and Policy Holder's SSN____________________________________

FAMILY INFORMATION

Parents are: Married--Divorced--Single

Guardian's willingness to join counseling:

Mother (Yes --No--Maybe) Father (Yes --No--Maybe) Other: ________________ (Yes --No--Maybe)

PARENT SECTION

**This information is important for your child's care and needs to be filled out by the first counseling session. 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.

Mother's/Guardian's Name: ____ Phone Contact: ____________________
Mother's /Guardian's Address: ____
Birth Date: _________ Age: _____ Ethnic Origin: ____
Mother's /Guardian's e-mail Address: ____
Total years of education completed: ____________ Occupation: ___________________________
Place of Employment: ____ Work Phone (____) __________________
Military experience? Y/N ____________ Combat experience? Y/N _________________
Assessment of current relationship if applicable: Poor_____ Fair_______ Good_________

Father's/Guardian's Name: ____ Phone Contact: _____________________
Father's/Guardian's Address: ____
Birth Date: _________ Age: _____ Ethnic Origin: ____
Father's/Guardian's e-mail Address: ____
Total years of education completed: ____________ Occupation: ___________________________
Place of Employment: ____ Work Phone (____) __________________
Military experience? Y/N ____________ Combat experience? Y/N _________________
Assessment of current relationship if applicable: Poor_____ Fair_______ Good_________

Any Other Active and Authorized Guardian's Name: _____________________________ Phone Contact: _____________
Relationship to youth__________________ Address: ____
e-mail Address: ____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship	Age	Sex	Type	Living with you?
	(Parent, Sibling, etc.)			(Bio, Step, etc.)	

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

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 _____%

Custody:

Who has legal custody of the child? Parents Mother Father Grandparents DCFS Other: ______________

Are there any custody considerations of which the counselor should be aware? _________________________________

Who has decision making Authority of Behavioral Health? ____

Visitation: ____

Copy of Custody Arrangement has been provided to be on File: Yes _____ No______

Is Child Adopted ____________ If Yes, where and at what age? ____

If child is adopted, what does the child know about the adoption and/or Birth Family? ____________________________

____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

__Fighting
__Feeling distant
__Loss of fun
__Lack of honesty
__Medical Concerns
__Education problems
__Financial problems
__Death of a family member
__Inadequate health insurance
__Inadequate housing/feeling unsafe
__Disagreeing about relatives
__Disagreeing about friends
__Alcohol or Drug use
__Trauma
__Infidelity (couple)
__Divorce/separation
__Issues regarding remarriage
__Birth of a child
__Job changes or job dissatisfaction
__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: ____
____
____

Current Reason For Seeking Counseling For Your Adolescent

Briefly describe the problem for which your adolescent is seeking to have counseling.

____
____

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: ____

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 and if so by who and when given?

____

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 _____
Has your son or daughter ever been suicidal? Yes___ (current or past) No ___ ?
Has your son or daughter ever used self-harm Yes___ (current or past) 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 or health problems with the pregnancy or Birth of your child? 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 from 1 to current in their life? 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.

____

____

SCHOOL HISTORY

How are your child's grades: (circle one)

(A's) (A's & B's) (B's) (B's & C's) (C's) (C's & D's) (D'S) (D's & F's) (F's)

Is there anything else you would like me to know about their school experience:

____

____

PEER RELATIONS

How would you describe your child socially? ___outgoing ____shy ____depends on the situation.

Are you happy with your child's friend (Y/N)________________

What pros and cons do you see in your child's friends?

____

____

____

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: ____
____
____
____
____

BELOW/NEXT IS ADOLESCENT SECTION

ADOLESCENT SECTION

(To be filled out by the adolescent as able).

CURRENT REASON FOR SEEKING COUNSELING (Adolescent's View)

Please provide a brief explanation of the events or issues that led to the need to seek counseling services:

____

____

____

____

What would you like to see happen as a result of counseling?

____

____

____

PERSONAL STRENGTHS (Adolescent's View)

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)

____

____

COUNSELING/MEDICAL HISTORY (Adolescent's View)

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?

____

____

If you have been given a previous diagnosis, what was it?

____

Who was it by ____and when? ______________________

ALCOHOL AND DRUG USE (Adolescent's View)

How would you describe your use of alcohol or drugs? (Circle one) Never used, Use, Misuse, Abuse

If you have used drugs or alcohol, what types, for what reasons, with whom, when, and how often (Daily, Weekly, Occasionally, Rarely?) ____

____

____

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?? _______

Please describe what history of drug or alcohol problems may exist in your family or close relationships?

____

____

____

LEGAL ISSUES (Adolescent's View)

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. ____

____

SCHOOL HISTORY (Adolescent's View)

Do you like school? (Y/N) ______________
Do you attend regularly? (Y/N) _____________
If you are in school, what kind of grades do you make: (circle one)

(A's) (A's & B's) (B's) (B's & C's) (C's) (C's & D's) (D'S) (D's & F's) (F's)

How is/was your attendance? ___________________________________

Do you feel you are doing the best you can at school? (Y/N) ________
What is/was your current/last level of education? ____

Is there anything else you would like me to know about school?

____

____

What do you see yourself doing (goals) in:

Short term (6 Months) ____
Midterm (1 Year) ____
Long term (5 Years) ____

PEER RELATIONS (Adolescent's View)
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 you or have you been dating (Y/N) ________ and if so with (Male, Female or other)?
Are you involved in any organized social activities (e.g. sports, scouts, music)? __________________________

____

Does your parent (s) like your friends? _______ How would they describe the people you most hang out with?

____

____

Who is your best friend and what would I see you and your best friend most often doing together?

____

____

If your guardians were fussing at you, what would they be fussing about and how would this differ between each Guardian? ____

____

____

FAMILY HISTORY (Adolescent's View)

Are your parents married/together or divorced/separated? ______________________

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: Adolescent 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 ____

Have there been an significant changes in the past 9 months (Death, Moves, Crisis, Changes in relationships, Job, School etc.)____

____

____

____

____

____

CURRENT PROBLEM IMPACT (Adolescent's View)

On a scale of 1-10, how much does this problem that brought you in interfere with your everyday living?
1 = little.........10 = greatly __________________ Are you or have you been suicidal? Yes___ (current or past) No ___
Have you ever used self-harm Yes___ (current or past) No ___?

What caused you to seek counseling at this time? ____
____
____

What thoughts, feelings, and behaviors are associated with your problem? ____
____
____
____

How does the problem interfere with your everyday living? ____
____
____
____

Do you have any physical stress related complaints? ____

When did this problem that brought you in first appear? ____

How often does the problem affect your life? ____
____
____

Do you notice any patterns (people, places, or events/before, during or after) that surround the problem? ____________
____
____

What actions have you taken to deal with the problem? ____
____
____

What strengths do you have that have helped you deal with the problem? ____
____
____

Who is on your side that is or could be helpful with this struggle you are facing? __________________________________
____

What are the top three things you most want to see different regarding this issue from counseling?

____
____
____
____