Please save the completed form and email it to frontdesk@panamacitywellness.com

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: _____ Today's Date: _____ Gender M__ F__

Would like to be called: _____ Date of Birth: ____/_____/_____ Race/Ethnicity _____

E-Mail address: _____ Month Day Year

Social Security Number: _____ Who referred you to this office? _____

Email Address: _____ Is Leaving Messages on personal numbers if needed okay? ____

Address: _____ Home Phone (____) _____

_____ Cell Phone (____) _____

_____ Parent's Cell (____) _____

School: _____Grade: _____ Employer: _____

Hobbies/Clubs: _____ Phone #: _____

_____ GW Counselor: _____

Religious Beliefs: _____ 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 (Parent, Sibling, etc.)	Age	Sex	Type (Bio, Step, etc.)	Living with you?
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
- ___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 change or job dissatisfaction
- __ 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?

_____
_____
_____
_____