

Intake Questionnaire - Teen

Note: This questionnaire is meant to be confidential. Keep in mind as you are filling this out that you may not be comfortable with your parents seeing some of your answers. If this is the case you may finish those questions once in session. We can discuss then if those answers are anything that may or may not be important for your parents to know at some time.

Client Name:

Date:

What is your main reason for seeking counseling?

List the primary goals you would like to achieve through counseling

A
B
C
D

Please describe any significant problems or stressors, and length of time experiencing, in any of the following:

- A. Mental or Emotional:
- B. Family Relationships:
- C. School:
- D. Health:
- E. Legal Concerns:
- G. Friendships:

Please mark "S" for Satisfied and "D" for Dissatisfied in the following categories (Mark N/A if it doesn't apply to you)

- | | |
|---|---|
| <input type="checkbox"/> Home Situation | <input type="checkbox"/> Romantic Relationships |
| <input type="checkbox"/> Job Situation | <input type="checkbox"/> Relationship with Friends |
| <input type="checkbox"/> Family Support | <input type="checkbox"/> Ability to Care for Yourself |
| <input type="checkbox"/> School | <input type="checkbox"/> Financial Situation |

What kind of grades do you generally get? Have they gone up or down recently?

Do you drink alcohol? If so how often?

Do you use any drugs? If so what and how often ?

What, if any, religion do you belong to?

What is your activity level with your faith?

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What, if any, prescription medication do you take?

Medication	Condition Treating	Dose	How Often	When Started

Do you take your prescribed medications regularly?

Do you suspect you may misuse any prescription medication?

Do you drink caffeine? If so, what type?

Do you smoke cigarettes? If so how often ?

What over the counter medications do you use? How often?

Do you use any vitamins, herbs or supplements? If so, how often?

How often do you exercise?

How well do you sleep?

Do you have a job? If so, where?

Are you concerned about your physical safety? If so, please explain.

Do you identify yourself as Heterosexual, Gay, Lesbian, Bi-sexual, or Other (if other, please explain)

Have you had sex?

Are you currently in a romantic relationship?

Do you have any history of trauma? (i.e., sexual assault, been in an accident, witnessed violence, history of abuse)

Are both of your parents living?

Are your parents married, divorced or other (if other, please explain)

Do you have any step-parents or step/half siblings?

If your parents are divorced/separated which do you live with? How often do you see the other?

Are you involved with any afterschool activities (whether through your school or not)?

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Please check any symptoms that you have recently experienced:

- | | |
|---|--|
| <input type="checkbox"/> Muscles twitches | <input type="checkbox"/> Wish You Could Never Wake Up |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Forgetfulness |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Racing Thoughts or Speech |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Tendency to Go Off on Tangents |
| <input type="checkbox"/> Over-aggressiveness | <input type="checkbox"/> Difficulty Speaking |
| <input type="checkbox"/> Withdrawn from family or friends | <input type="checkbox"/> Racing Heart |
| <input type="checkbox"/> Stealing or Dishonesty | <input type="checkbox"/> Fear of Abandonment |
| <input type="checkbox"/> Destructiveness | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Disorganization | <input type="checkbox"/> Flashbacks of Distressing Events |
| <input type="checkbox"/> Trouble with Authority Figures | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Breaking Rules, Pushing Limits | <input type="checkbox"/> Fear of Open Spaces |
| <input type="checkbox"/> Injuring Self (i.e. cutting, hair pulling, burning, etc) | <input type="checkbox"/> Unsure of What is Real |
| <input type="checkbox"/> Anger or Hostility | <input type="checkbox"/> Feel Like You are Outside Your Own Body |
| <input type="checkbox"/> Apathy | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Emotional Highs | <input type="checkbox"/> Obsessions |
| <input type="checkbox"/> Feeling Guilty | <input type="checkbox"/> Fears of Being Watched or Manipulated |
| <input type="checkbox"/> Helplessness | <input type="checkbox"/> Murderous Thoughts or Wishes |
| <input type="checkbox"/> Feelings of Rejections | <input type="checkbox"/> Eating Disorder -starving/binging/purging |
| <input type="checkbox"/> Low Self-Esteem | <input type="checkbox"/> Emotional Eating |
| <input type="checkbox"/> Reduced Interest/Enjoyment in Life | <input type="checkbox"/> Unable to Maintain Normal Weight |
| <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Dissatisfied with Body Shape or Weight |
| <input type="checkbox"/> Difficulty Making Decisions | <input type="checkbox"/> Concern Over Use of Any Substance(s) |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Persistent Desire for Any Substance(s) |

**Family History - Please check any of the following that apply that you are aware of and note if in: A - Yourself,
B - Your immediate family, C - The family you grew up in, D - Other relatives**

- | | |
|---|--|
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Family "Secrets" |
| <input type="checkbox"/> Other Addictions | <input type="checkbox"/> Infidelity |
| <input type="checkbox"/> Sexual Abuse/Assault | <input type="checkbox"/> Chronic Lying |
| <input type="checkbox"/> Physical Abuse/Assault | <input type="checkbox"/> Children Out of Wedlock |
| <input type="checkbox"/> Mental or Emotional Abuse | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Religious Abuse |
| <input type="checkbox"/> Suicide or Attempted Suicide | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Teen Pregnancy |