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)

__Home Situation
__Job Situation
__Family Support
__School
__Romantic Relationships
__Relationship with Friends
__Ability to Care for Yourself
__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:

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- ☐ Withdrawn from family or friends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

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