

Patricia Holden M.A., M.F.T.  
Licensed Marriage & Family Therapist  
[www.edlightenment.com](http://www.edlightenment.com)

Adolescent Intake Information

The information you are providing will be kept confidential, unless by law I am required to provide it.

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Referred by \_\_\_\_\_

Street Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Email Address \_\_\_\_\_

**Parent Contact Information**

**Primary parent contact (either custodial parent or one easiest to reach)**

Name \_\_\_\_\_

Parent's Work Phone # \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

**Other parent/caregiver contact information**

Name \_\_\_\_\_

Parent's Work Phone# \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

**Personal Information**

Please list the members of your family by name, relationship, and their ages.

**Circle** the number of those who currently live in your home.

	<u>Name</u>	<u>Relationship</u>	<u>Age</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

**What problem(s) have led you and your parents to seek help at this time?**

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**What would you like help with?**

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**Do you feel that therapy can help you? (circle one)      Y      N**

**Why or why not?** \_\_\_\_\_

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**School**

Describe any academic problems you have experienced in the past or currently.

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List any problems or conflicts you have had at school, apart from academics.

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*Use the back side of the paper if you need more room.*

**Social**

Do you make friends easily? **(circle one)**                      **Y**                      **N**

How many close friends do you have? \_\_\_\_\_ How many acquaintances? \_\_\_\_\_

How would you describe these friendships?

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Club/Organizations You Participate In

_____	_____
_____	_____
_____	_____

Your Religious affiliation? \_\_\_\_\_ Active? **(circle one)**   **Y**   **N**

Own pets? **(circle one)**   **Y**   **N**

**Experience with mental health professionals**

Have you received therapy in the past? **(circle one)**      **Y**      **N**

Whom have you seen? (I will not contact this person without your permission).

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Individual Therapy \_\_\_\_\_ Group Therapy \_\_\_\_\_

Quality of experience with therapist **(rate by circling a number)**

(negative)    1    2    3    4    5    6    7    8    9    10    (positive)

Have you ever been in the care of a psychiatrist?      **(circle one)**    **Y**      **N**

Whom have you seen? (I will not contact them without your permission.)

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Quality of experience with psychiatrist **(rate by circling a number)**

(negative)    1    2    3    4    5    6    7    8    9    10    (positive)

Diagnosis :    Depression \_\_\_\_\_ Anxiety \_\_\_\_\_ ADHD \_\_\_\_\_ Bipolar Disorder \_\_\_\_\_

Medications you were prescribed:

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**Alcohol/Drugs**

Do you use alcohol? (circle one) **Y** **N**

How often and how much do you drink? #drinks\_\_\_\_\_per week

Do you use any drugs (including marijuana, ecstasy, cocaine, pain killers): **Y** **N**

How often do you use drugs: \_\_\_\_\_times per week

What kind? \_\_\_\_\_

Have you ever felt that alcohol or drugs are a problem for you? **Y** **N**

Have you received professional help for alcohol or drug problems? **Y** **N**

If yes, where and when were you treated?

\_\_\_\_\_How long\_\_\_\_\_Date\_\_\_\_\_

\_\_\_\_\_How long\_\_\_\_\_Date\_\_\_\_\_

\_\_\_\_\_How long\_\_\_\_\_Date\_\_\_\_\_

**Other Health Information**

Over the past year have you been under the care of a physician for a specific illness or

Injury? (circle one) **Y** **N**

What have you seen a doctor for? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any history of: (please check  any that apply)

Headaches \_\_\_\_\_Chronic pain \_\_\_\_\_Allergies \_\_\_\_\_Asthma \_\_\_\_\_

Head Injuries \_\_\_\_\_ Broken Bones/Muscle Injuries\_\_\_\_\_

Any other health issues or injuries?

\_\_\_\_\_

\_\_\_\_\_

Please list any surgeries you have had.

\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

What childhood illnesses have you had (ear infections, measles, chicken pox, shingles)?

\_\_\_\_\_  
\_\_\_\_\_

Do you wear glasses? (circle one)      Y      N

**Thank you for your time answering these questions. If you have any questions or concerns about therapy or about me, please write them here:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Printed Name \_\_\_\_\_