TalkaWhile
Child and Family Therapy Center PC

ADOLESCENT INTAKE FORM – (Ages 12-17)

This questionnaire will help us to get to know a little more about you and how we may be of help. If you feel uncomfortable with any question, you can choose to talk about this later and we can discuss it privately when we meet. Please complete this questionnaire as honestly and as completely as possible.

All responses you provide will be kept confidential unless you choose to release this information to someone or report that you are seriously harming yourself or someone else, or someone has seriously harmed you.

PERSONAL INFORMATION:

Name: _____ Date: _____
Date of Birth: _____ Age: _____
Gender Identity: □ Male □ Female □ Transgender □ Other: _____
Race/Ethnicity: _____
Religious Preference/Affiliation: _____
School Name: _____
School Grade: _____
Phone Number (Cell): _____ Messages Okay? □ Yes □ No
Phone Number (Home): _____ Messages Okay? □ Yes □ No

CURRENT REASON FOR SEEKING THERAPY:

Whose idea was it for you to be seen here today? □ Mine □ Parents □ Other

If the idea was someone else's, are you okay with this idea? □ Yes □ No □ Unsure

Briefly describe the main problem or reasons for seeking help now. _____
_____
_____

What do you hope to get from this appointment and what would you like to see happen as a result of therapy/counseling? _____
_____
_____

How important is this change for you? _____

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THERAPY/COUNSELING HISTORY:

Have you previously been in therapy or worked with a therapist/counselor? □ Yes □ No
If yes, with whom did you work and what did you find most helpful in therapy?

_____
_____
_____

If yes, what did you find least helpful in therapy and what did not work for you?

_____
_____
_____

FAMILY INFORMATION:

Please describe your family (parents, stepparents, guardians, siblings) with whom you live.

Name	Relationship To You	Our Relationship Is: Poor Average Good	Spends Time With Me	Overuses Alcohol/Drugs
		□ □ □	□	□
		□ □ □	□	□
		□ □ □	□	□
		□ □ □	□	□
		□ □ □	□	□
		□ □ □	□	□
		□ □ □	□	□

Are your parents/caregivers: □ Unmarried □ Engaged □ Married □ Separated/Divorced □ Remarried □ Widowed

Do you think their relationship is good? □ Yes □ No

If your parents/caregivers are divorced, with whom do you primarily live? _____
_____

How often do you see each parent/caregiver?
Parent/Caregiver 1: _____% Parent/Caregiver 2: _____%

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Family Concerns

Do you have family concerns in any of the following areas? (Please check any that your family is currently experiencing)

- □ Fighting
- □ Feeling Distant
- □ Loss of Fun
- □ Lack of Honesty
- □ Disagreeing about Relatives
- □ Parent Job Loss
- □ Medical Concerns
- □ Marital Problems
- □ Divorce/Separation
- □ Custody Disputes
- □ Disagreeing about Friends
- □ Parent Infidelity
- □ Parent Alcohol/Drug Use
- □ Other:
- □ Financial Problems
- □ Housing Problems
- □ Death of Loved One
- □ Serious Family Illness
- □ Blended Family Issues
- □ Trauma

Life Stressors
Have your experienced any of the following in past or present?

Psychological abuse (e.g. you were harshly yelled at, repeatedly "put down," victim of controlling behavior). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Physical abuse (e.g. you were hit, kicked, beaten up, or threatened to be hit).
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Sexual abuse (e.g. inappropriately touched, molested, assaulted). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Neglect (e.g. left unattended for extended periods of time, lacked clothing, food, were left soiled/dirty, failed to be provided needed medical/dental care or treatment).
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____
_____

Witnessed violence at home (e.g. frequent verbal fighting, physical fighting, or sexual abuse among parents). □ Yes □ No □ Unsure
If yes or unsure, please explain. _____
_____

Talk a While
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Interpersonal/dating violence. □ Yes □ No □ Unsure
If yes or unsure, please explain. _____

Bullying, cyber-bullying by peers and/or classmates, or victim of peer violence.
□ Yes □ No □ Unsure. If yes or unsure, please explain. _____

SCHOOL INFORMATION:

How would you describe your current school performance? □ Poor □ Average □ Good

What is your current/most recent GPA? _____

Do you like school? □ Yes □ No □ Unsure

Do you attend school regularly? □ Yes □ No □ Unsure
If no or unsure, please explain. _____

Do you have any school problems? (Please check all that apply)

- □ Learning Problems
- □ Problems with Teachers
- □ Problems making Friends
- □ Suspensions/Expulsions (#_____)
- □ Discipline Referrals (#_____)
- □ Other School Problems:

Do you have any school-based supports (e.g. school counselor, group, teacher)? □ Yes □ No
If yes, please explain. _____
_____

Do you feel like you are doing the best you can at school? □ Yes □ No □ Unsure
If no or unsure, please explain. _____
_____

SOCIAL SUPPORT SYSTEMS:

Are you involved in any organized social activities (e.g. sports, band, dance, girl/boy scouts)?
□ Yes □ No
If yes, please provide additional information. _____
_____

How do you consider yourself socially?
□ Extroverted/Outgoing □ Introverted/shy □ Depends on the situation

How many good friends do you have that you can depend on for help if you needed them?
□ 0 □ 1 □ 2-3 □ 4 or more

How do you feel about your friendships?
□ Unsatisfied □ Neutral/Okay □ Satisfied

How do your parents feel about your friendships?
□ Unsatisfied □ Neutral/Okay □ Satisfied

How well do you get along with peers?
□ Poor □ Average □ Good

Relationships

Are you dating someone? □ Yes □ No

Are you sexually active? □ Yes □ No

Have you ever been pregnant (past or present)? □ Yes □ No □ Not applicable

What is your sexual orientation (e.g. straight, gay, bi)? _____

What is your gender identity and preferred pronoun (e.g. girl, she, they)? _____

SUBSTANCE USE AND HISTORY:

Please describe your current substance use.

	Never	Daily	Weekly	Occasionally	Rarely	Past Use Only
Alcohol						
Tobacco						
Marijuana						
Other Drugs						

Have you ever used more than 1 substance at the same time to get high? □ Yes □ No

Do you avoid family activities so you can use? □ Yes □ No

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Do you have a group of friends whom also use? □ Yes □ No

Have you received any previous treatment for chemical/substance use? □ Yes □ No
If yes, please explain where you went and if you were admitted into a hospital for this use.

_____

_____

SAFETY/RISK HISTORY:

Have you ever had current or past thoughts or feelings of?

	Never or not at all	In the past	Sometimes	Often	All the time
Hurting or injuring yourself on purpose	☐	☐	☐	☐	☐
Feeling it is too painful to keep living or that you would be better off dead	☐	☐	☐	☐	☐
Thoughts of suicide	☐	☐	☐	☐	☐
Thoughts about specific ways to kill yourself	☐	☐	☐	☐	☐
Thoughts about hurting or killing others	☐	☐	☐	☐	☐
Hearing voices or seeing things that are not there	☐	☐	☐	☐	☐
Feeling like people are out to get you	☐	☐	☐	☐	☐

CURRENT HEALTH HABITS:

How often do you exercise per day (average)?
□ 0 □ 30 minutes □ 1-2 hours □ 3 or more hours

What is your media, social media, and/or video game use per day (average # of hours)?
□ 0 □ 1-2 hours □ 3-4 hours □ 5 or more hours

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How much caffeine do you consume per day (e.g. coffee, soda, energy drinks)?
□ 0 □ 1-2 drinks □ 3-4 drinks □ 5 or more drinks

How much do you sleep per night?
□ 0 □ Less than 5 hours □ 6-7 hours □ 8-10 hours □ 11-12 hours

OTHER INFORMATION:

Tell us a little about yourself. _____
_____
_____

Describe your strengths and unique qualities. _____
_____
_____

Have you ever had any legal issues? □ Yes □ No
If yes, please explain. _____
_____

Have you experienced any sources of stress within the last year? □ Yes □ No
If yes, please explain. _____
_____

Do you feel overwhelmed by your current number of weekly extracurricular activities (e.g. sports, music, dance, academic courses outside of school)?
□ Yes □ No □ Unsure. Please explain. _____
_____

Is there any other information you would like us to know? _____
_____
_____