Hope Renewed Counseling Services LLC

ADOLESCENT INTAKE QUESTIONNAIRE

Today's date: _____

General Information

Name_____

Address _____

Home phone: _____Work phone:_____Cell phone:_____

Description of Presenting Problems

Circle areas in which you've noted difficulties or changes:

sleep	appetite	crying	concentration	weight
panic	social interaction	sexual activity	physical pains or sickness	
unusual behavior	depressive thinking	frightening thoughts	suicidal thoughts	

Have you experienced any significant life changes in the past year? Yes _____ No _____ If yes, please explain: _____

_____

Have you previously been in therapy? Yes _____ No _____

Previous therapy was related to: _____

_____

_____

List previous counseling experience, including dates and your response to therapy:_____

_____

_____

_____

Have you recently been on any medications: Yes _____ No _____

Type and dosage _____

_____

Physicians name: _____ Clinic _____

Address: _____ Phone: _____

Have you ever been hospitalized? Yes _____ No _____

Dates and reason: _____

_____

Substance Use

Do you use alcohol? Yes _____ No _____

Type, amount and frequency: _____

Do you use tranquilizers (valium, librium, xanax, etc.), narcotics, cocaine, marijuana, amphetamines or other substances: Yes _____ No _____

Describe: _____

_____

Personal and Social History

Where did you grow up? _____

Father's name _____

Marital Status _____ Occupation _____

Describe your relationship with your father_____

Mothers name _____

Marital Status _____ Occupation _____

Describe your relationship with your mother _____

Siblings (include age): _____

_____

_____

_____

Is there any illness or disorder that tends to ruin your family? Yes _____ No _____

Please explain: _____

_____

Have any of your family (grandparents, parents, aunts/uncles, your siblings) had any problems with the following?

Problem	Relative	Treatment
Alcohol/drug abuse		
Depression		
Bi-polar disorder		
Suicide		
Other emotional disorders		

School

Current grade: _____ Current school:_____

Favorite subjects: _____

Leaset favorite subjects: _____

How many schools have your attended? _____

Have you received testing or counseling in school? Yes _____ No _____

Do you attend any special education classes? Yes _____ No _____

Which ones? _____

How do you get along with classmates? _____

How do you get along with teachers? _____

What chores and responsibilities do you have? _____

_____

_____

How many close friends do you have? Male _____ Female _____

Please list hobbies, clubs, sports: _____

_____

How do you use free time? _____

_____

Your present living situation: (circle one)

Both parents one parent shared custody guardian/foster

Religious upbringing and current involvement: _____

_____

Is there any other information about you or your family that would be helpful for us to know?

_____

_____

_____

Client's Signature _____ Therapist Signature _____