Intake Questionnaire – Teen

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the Practice Policies form and the HIPAA Notice of Privacy Practices. If you do not desire to answer a question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to our first session.

LEGAL NAME: _____ TODAY'S DATE: _____

PREFERRED NAME (If different): _____ PRONOUNS: _____

CURRENT GENDER IDENTITY: _____ SEX ASSIGNED AT BIRTH: _____

SEXUAL ORIENTATION: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____EMAIL: _____

EMERGENCY CONTACT

Name: _____ Phone #: _____

PRIMARY CARE PROVIDER

Name: _____ Phone #: _____

PAST/PRESENT MEDICAL HISTORY (major medical problems, surgeries, accidents, falls, illness, etc.):

_____

_

_____

_

_____
_

CURRENT MEDICATION (list name, dosage, and reason for taking):

_____
_

_____
_

PRESCRIBING MD/PSYCHIATRIST (if different than care provider above)

Name: _____ Phone #: _____

PAST/PRESENT PSYCHOTHERAPY

List all mental health professionals you have worked with (please specify when, for how long, name, phone number, initial reason for therapy, beneficial or not, why it ended):

_____
_

_____
_

FAMILY MEDICAL HISTORY

History of mental illness/alcoholism/violence in family *Yes ☐ No ☐ Unsure ☐

*If yes, please explain: _____

PARENTS/STEPPARENTS (name/age or year of death/cause of death, occupation, personality, how they treat/ed you, brief statement about the relationship):

Father: _____

_____

_

_____

_

Mother: _____

_____

_

_____

_

Stepparents: _____

IF PARENTS DIVORCED:

Your age at the time: _____

How did it affect you at the time and does it impact you today? _____

_____

_

_____

_

SIBLINGS (name/age, if deceased: age and cause of death and brief statement about the relationship):

_____

_

_____

_

_____

RELATIONSHIP STATUS

Are you currently in a relationship?

*Yes ☐ No ☐

*If yes, please describe nature of the relationship and how long you have been together:

_____
_

_____
_

_____

EMPLOYMENT

*Yes ☐ No ☐

*If yes, please describe what you do/where you work: _____

_____

_____

EDUCATION

Are you currently in school (i.e. high school, college, trade school)?

*Yes ☐ No ☐

*If yes, please describe how you are doing academically in your classes:

_____

_____

_

LIVING SITUATION (please describe who you live with and how you feel about this living situation):

SUPPORT SYSTEM (describe who supports you currently): _____

_____

_

SUBSTANCE USE

Do you drink alcohol? *Yes ☐ No ☐

*If yes, describe quantity/frequency: _____

Do you use recreational drugs? *Yes ☐ No ☐

*If yes, describe quantity/frequency: _____

How are alcohol and drugs discussed at home? _____

_____

_

Have you struggled or do you currently struggle with alcohol or drug use or abuse?

Yes ☐ No ☐

SEXUALLY ACTIVE:

Yes ☐ No ☐

How is intimacy and/or sex discussed at home? _____

LEGAL

To the best of your knowledge, is your teen involved in any current or pending civil or criminal litigation/s or lawsuit/s?

*Yes ☐ No ☐

*If yes, please explain: _____

PLEASE PROVIDE AN OVERVIEW OF YOUR CHILDHOOD (noteworthy familial relationships, school, neighborhood, relocations, behavioral/problems, abusive/alcoholic parent, etc.):

ESTIMATE HOW MANY HOURS PER DAY YOU SPEND ONLINE:

Social media: _____ Gaming: _____ Texting: _____ Browsing: _____ TV: _____

Work/School: _____ Other: _____

Do you feel your technology use is balanced/healthy or could use improvement?

CHECK ALL THAT APPLY:

- ☐ Headache
- ☐ High blood pressure
- ☐ Gastritis or esophagitis
- ☐ Hormone-related problems

☐ Head injury
☐Angina or chest pain

☐ Irritable bowel
☐ Chronic pain
☐ Loss of consciousness
☐ Heart attack
☐ Bone or joint problems
☐Seizures
☐ Kidney-related issues
☐ Chronic fatigue
☐ Dizziness
☐ Faintness
☐ Heart valve problems
☐ Urinary tract problems
☐ Fibromyalgia
☐ Numbness & tingling
☐ Shortness of breath
☐ Diabetes
☐ Hepatitis
☐ Asthma
☐ Arthritis
☐ Thyroid issues
☐ HIV/AIDS
☐ Cancer
☐ Other: _____

CHECK ANYTHING YOU HAVE EXPERIENCED IN PAST 6 MONTHS:

☐ Increased appetite
☐ Decreased appetite
☐ Trouble concentrating
☐ Difficulty sleeping
☐Excessive sleep
☐ Low motivation
☐ Isolation from others
☐ Fatigue/low energy
☐ Low self-esteem
☐ Depressed mood
☐ Self-harm or cutting
☐ Anxiety

☐ Fear
☐ Hopelessness
☐ Panic
☐ Suicidal Thoughts
☐ Other: _____

PRESENTING PROBLEM (describe what circumstances/events encouraged you to seek out therapy at this time, provide as much detail as possible)

_____
_

_____
_

Estimate the severity of above problem: Mild ☐ Moderate ☐ Severe ☐ Very severe ☐

Have you ever been hospitalized for a psychiatric issue?

Yes ☐ No ☐

Have you ever attempted suicide?

Yes ☐ No ☐

Do you currently have suicidal thoughts?

Yes ☐ No ☐

Do you struggle with violent thoughts and/or behaviors towards self?

Yes ☐ No ☐

Do you struggle with violent thoughts and/or behaviors towards others?

Yes ☐ No ☐

What is your favorite thing about yourself? _____

Do you do any extracurricular activities? If so, which ones? _____

Where do you feel most peaceful? _____

What are your goals for therapy? If you got exactly what you needed out of therapy, what would we have accomplished together?

Is there anything else you would like me to know about you?