Intake Questionnaire – Parent

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

YOUR NAME: _____ YOUR TEEN'S NAME: _____

TODAY'S DATE: _____ YOUR TEEN'S DATE OF BIRTH: _____

YOUR ADDRESS: _____

TELEPHONES:

Your Home #: _____ Your Cell #: _____

FOR ROUTINE MESSAGES:

Preferred Phone #: _____ Preferred Email: _____

FOR CONFIDENTIAL/PRIVATE MESSAGES:

Preferred Phone #: _____ Preferred Email: _____

Preferred Phone # for text: _____

REFERRAL SOURCE: _____

May I send them a thank you note for the referral? Yes ☐ No ☐

YOUR TEEN'S PRIMARY CARE PROVIDER:

Name: _____ Phone #: _____

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

_____
_

_____
_

YOUR TEEN'S CURRENT MEDICATION (list name, dosage, and reason for taking):

_____
_

_____
_

YOUR TEEN'S PRESCRIBING MD/PSYCHIATRIST (if different than care provider above):

Name: _____ Phone #: _____

PAST/PRESENT PSYCHOTHERAPY

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

_____
_

_____
_

FAMILY MEDICAL HISTORY

History of mental illness/alcoholism/violence in your family?

☐Yes* ☐No ☐Unsure

*If yes, please explain: _____

Any other illness that runs in the family (i.e., cancer, epilepsy, etc.)?

_____
_

What is your occupation? Please describe how you balance work and family.

_____

_____

PAST/PRESENT SUICIDE ATTEMPT/S, PSYCHIATRIC HOSPITALIZATION/S, AND/OR VIOLENT BEHAVIOR/S

To your knowledge, does your teen have history with any of the above? If recalled, please include ages and circumstances of event, as well as any other information you think I should know:

_____
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_____
_

_____
_

YOUR TEEN'S PRESENTING PROBLEM

Why are you seeking therapeutic services for your teen? When did you begin noticing these symptoms/behaviors/changes? How does your teen's presenting problem affect you?

_____
_

_____
_

How would you rate the severity of above problem:

Mild ☐ Moderate ☐ Severe ☐ Very severe ☐

What elements of your teen's developmental history/childhood are important for me to know?

_____

_____

_____

ALCOHOL/DRUG USE

To your knowledge, does your teen drink alcohol or use recreational drugs?

*Yes ☐ No ☐

Is your teen's alcohol and/or drug use of concern to you?

*Yes ☐ No ☐

*If yes to either of the above, please elaborate: _____

_____
_

How are alcohol and drugs discussed at home? _____

_____
_

_____
_

SEXUAL BEHAVIOR

To the best of your knowledge, is your teen sexually active?

*Yes ☐ No ☐

Is your teen's sexual activity of concern to you?

*Yes ☐ No ☐

*If yes to either of the above, please elaborate: _____

_____
_

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: _____

TECHNOLOGY

Please estimate how many hours a day your teen spends on screens:

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

Work/School: _____ Television: _____ Other: _____

Do you feel your teen's screen time is balanced/healthy or needs improvement? Please explain:

_____
_

_____
_

SYMPTOM CHECKLIST

CHECK ALL THAT APPLY to your teen (to the best of your knowledge):

- ☐ 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 THAT APPLIES to your teen (to the best of your knowledge) in the last 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: _____

ADDITIONAL QUESTIONS

Where does your teen go to school and what grade are they in?

_____

Please describe how your teen does in school (both academically and socially):

_____

_

_____

_

What is your teen's current living situation? If your teen rotates between homes please describe the custody schedule below:

_____

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_____

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_____

_

Has anyone else in your family attended therapy? Did they benefit from the experience?

_____

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_____

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_____

_

Has your family ever been to family therapy? If so, was it effective?

☐ Yes* ☐ No

*If yes, for how long? And was it effective? _____

_____

What are your goals for counseling for your teen? What do you think your teen's goals are? Do you have the same or different goals?

_____

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_____

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_____

_

What are your teen's strengths? How can these strengths help them in therapy?

_____

_____

What do you see as your child's weakness or challenges? How have you learned to work with or address these challenges?

_____

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_____

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

_____

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NOTE: My policy is never to bring up the possibility of taking medication with teens before addressing it with their parents first (even if the teenager brings it up). Therefore, please describe below under what circumstances (if any) you might consider psychiatric medications for your child. Please let me know if this is something you would like to address during our initial phone call.

_____

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