

**Hardy & Stephens Counseling Associates
Adolescent Intake**

Name: _____

What is bringing you to counseling at this time?

What areas of your life do you feel are impacted by this problem/issue?

___ School ___ Home ___ Peers ___ Family ___ Daycare ___ Neighbors
___ Siblings ___ Parents ___ Relatives ___ Other

Family History:

Family Constellation (who is in your family):

Name	Age	Gender	Relationship	Ethnicity	Location

Current Living Situation (who do you live with):

What kind of support system do you have in place?

How would you describe the peer relationships you have?

What leisure activities do you enjoy?

How would you describe your current family relationships?

Are you employed?

If so, where?

How many hours per week?

Religious Background

What is your religious preference (denomination)?

How important is your faith/religion in your life?

Current and Past Chemical Use:

Do you drink alcoholic beverages? No Yes If yes, what do you drink? Beer
 Wine Hard Liquor

How often do you drink? Daily 3-5times weekly 1-2 times weekly
 Less frequently

Do you sometimes drink more than you had planned? No Yes

Have family or friends ever expressed concern about your drinking? No Yes

Have you ever been arrested for alcohol related charges: DWI, public intoxication, etc?
 No Yes

Have you ever been treated for drinking or gone to AA? No Yes

Have you ever had episodes where you were unable to remember periods when you were drinking? No Yes

What has been your experience with the following?	Use currently	Used in past	Never used
Tranquilizers: valium librium azene milltown equanil xanax centrax			
Pain Pills/Narcotics: darvon codeine percocan demerol dilaudid heroin talwin			
Stimulants: amphetamines speed dexedrine ritalin white crosses zip cocaine & derivatives crack, crank methamphetamine			
Sleeping Pills/Soporifics: doriden placidyl dalmane seconal tuinal nembutal amytal phenobarbital noctec somnos			
Hallucinogens: marijuana hashish THC LSD Mescaline psilocybin MDA PCP Angel Dust Mushrooms			
Volatiles: Aerosols paint thinner glue lacquer amyl or butyl white "poppers" gasoline			
Others (please list):			

Have family or friends ever expressed concern over your use of drugs? No Yes

Have you ever been arrested for any offense involving drugs? ___No ___Yes

Have you ever been treated for chemical dependency? ___No ___Yes

Have you ever overdosed on drugs (accidental or purposeful)? ___No ___Yes

PSYCHOLOGICAL HISTORY

Have you been in counseling before? If so, with who, where and for how long?

Was it helpful to you?

Has anyone else in your family had any mental health issues like depression or anxiety?

How do you feel about school?

What activities are you involved in? (sports, music, drama, clubs, etc.):

Special Services/Groups/Support Groups:

How do you get along with your teachers?

What would you describe as your strengths or things you do well?

What are your vulnerabilities or areas of weakness?

Is there anything else you think would be important for us to know in helping you?

Adolescent Intake (parent form)

Name of person completing this form: _____

Relationship to client: _____

Why are you bringing your child to counseling at this time?

What areas of your life do you feel are impacted by this problem/issue?

School Home Peers Family Daycare Neighbors

Siblings Parents Relatives Other

What discipline strategies/techniques do you utilize with your child?

Spanking Reasoning Sending to Room Yelling Removing

Privileges Grounding

Effectiveness:

Please describe any legal history your child has (eg: acting out, fire starting, cruelty to animals, truancy, etc.)

Developmental & Medical History:

Duration of Pregnancy:

Where there any complications during the pregnancy or delivery? If so, please describe:

Any alcohol/cigarette/drug use prior to or during the pregnancy?

Health at birth:

Please describe your child's disposition as a baby:

Developmental milestones:

Milestone	On Time	Delayed
Speech		
Motor		
Cognitive		
Adaptive		
Social		

Did your child receive any early intervention services?

Does your child have any significant medical concerns or is there any significant family medical history (include allergies, infectious diseases & relevant medical concerns)?

Please list all medications your child is currently taking:

Medication	Dosage	Prescribing Physician

Primary Care Physician:

May we contact them?

Clinic:

Address and Phone:

Please describe any sleeping or eating problems your child may have:

Has your child had any toileting problems?

Does your child have a history of a head injury?

Psychological History

Has your child had any previous therapy or mental health issues?

Please list any previous therapy or assessments (including therapist, date, location, and for what):

Is there any family history of mental health concerns (depression, anxiety, etc.)?

Is there any family history of chemical dependency, alcoholism or treatment?

School Information:

Current School: _____ Grade: _____

Phone Number: _____

Teacher: _____ Social Worker: _____

Previous Schools Attended

School name & location	# of years attended	Phone number

Current achievement (grades, special honors, IEP):

School behavior (include detentions, suspensions):

Social relationships (with peers, teachers, etc.):

What would you describe as your/your child's strengths?

What are your/your child's vulnerabilities?

Is there anything else you think would be important for us to know in helping you/your child?