Client Intake Questionnaire - Teen

General Information

Name: ______________________________ _____________________________

Last First

Today's Date: _________________

If applicable, name and relationship to client of person filling out form: _________________________

If student, school attending:

____

Highest education completed: ___________________________

Satisfaction with school (1-10, 1 = lowest) ______________

Occupation: ____

Satisfaction with job (1-10, 1 = lowest) _________________

Place of employment: ____

Length of employment: ___________________

Presenting Concern

Reason for seeking services:

Did a specific event lead to this search for service? If yes, please describe the incident:

Other relevant history of the problem(s):

Please describe what you hope to accomplish in this therapy or what you hope will be different in your life when this therapy is helpful to you.

Parent/Guardian Initials:___________

Please rate the severity of your concerns/symptoms on a 1-10 scale. How much is your life affected in the following roles or areas? (Please check the number that best applies)

	No Impairment					Moderately Impaired					Extremely Impaired
Self Care/Personal	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
Family Life	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
Social Life	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
Academic Life	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

Contributing Factors

Which of the following do you think contribute to your problem(s)? (Check all that apply)

☐ Move to a new home	☐ Remarriage of parent/step-parent	☐ Death of friend or family member
☐ Birth of a sibling	☐ Break up with a boy/girlfriend	☐ Physical/Sexual Abuse
☐ Conflict with a sibling	☐ Peers are a negative influence	☐ Previous therapy
☐ Parents arguing	☐ Drugs or alcohol use	☐ Medical problems
☐ Separation of parents	☐ Bullying/Violence	☐ Other: _______________

Parent/Guardian Initials:___________

Mental Health History

Other therapy or counseling treatment you've received in the past or are receiving now (Please indicate when and for how long):

Have you ever been hospitalized for psychological problems? If yes, when and where?

Have you ever attempted suicide? If yes, when?

Current medications & dosage (if applicable):

Parent/Guardian Initials:___________

Substance Use

Please indicate which best describes your use of the following substances. If daily, please indicate amount:

	DAILY/AMOUNT	WEEKLY	OCCASIONALLY	IN THE PAST, BUT NOT NOW	NOT AT ALL
CAFFEINE / ENERGY DRINKS					
TOBACCO					
ALCOHOL					
PRESCRIPTION NARCOTICS					
INHALANTS					
COCAINE / METH / AMPHETAMINE					
OPIATES / SEDATIVE - HYPNOTICS					
HALLUCINOGENS					
CANNABIS					
OTHER:					

Have you or anyone else ever been concerned about your use of any of the above substances? If yes, describe:

Have you ever had treatment for any type of substance use? If yes, when? And please describe:

Parent/Guardian Initials:___________

Legal History

Please note any legal difficulties, including pending charges, arrests, convictions, probation, nature of charges, etc.:

Medical History

Please list any significant health problems, past or present, including surgeries, illness, head traumas, and/or important accidents or injuries with the corresponding dates:

Please describe any significant family medical problems, and any family history of mental illness or substance abuse:

Family Information & Significant Relationships

Please provide names of any significant relationships you'd like to mention.

FIRST NAME	**Age**	**RELEVANT INFORMATION (e.g., Date of Death, City/State, Occupation(s), Religion)**
Grandparents:	**Age:**	**Relevant Information (Optional)**
Aunts & Uncles (Paternal)	**Age:**	**Relevant Information (Optional)**
Aunts & Uncles (Maternal)	**Age:**	**Relevant Information (Optional)**

Parents & Step-parents	**Age:**	**Relevant Information (Optional)**
Brothers & Sisters	**Age:**	**Relevant Information (Optional)**
Children (if applicable)	**Age:**	**Relevant Information (Optional)**

Other Significant Relationships: (e.g., Partner, Partner's Family Members, Important Friendships, Roommates, etc.)
Quality of interpersonal relationships and social interactions:

Parent/Guardian Initials:___________

Check any of these that apply:

- Depressed, sad or crying
- Grieving
- Guilty feelings
- Suicidal thoughts, plans or attempts
- Self-harm (e.g. cutting)
- Thoughts of harming others
- Difficulty falling or staying asleep
- Fatigue, always feeling tired
- Nightmares
- Increase or decrease in weight or eating habits
- Lack of interest in recreation/pleasurable activities
- Problems managing daily self-care tasks
- Apathy
- Inability to focus
- Lack of direction
- Lack of meaning in life
- Anxious, nervous or panicky feelings
- Panic attacks / anxiety attacks
- Fears/phobias
- Avoiding places or situations
- Insecurity or inferiority
- Repetitive thoughts or behaviors
- Anger or temper problems
- Headaches or body aches
- Upset stomach

- Memory problems
- Confused or disorganized thoughts
- Seeing/hearing things that aren't there
- Paranoia
- Loneliness
- Being picked-on or taken advantage of
- Relationship dissatisfaction/problems
- Conflicts with others
- Problems making or keeping friendships
- Social alienation / Not fitting in
- Not wanting to be around other people
- Substance abuse or dependence
- Sexual abuse
- Physical abuse
- Emotional abuse
- Fighting
- Hyperactivity
- Staying up all the time, but never feeling tired
- Financial problems
- Impulsive spending
- Illegal activities
- Sexual worries or problems
- Sexual orientation or identity concerns
- Learning disability
- Religious/spiritual concerns
- Problems at work and/or school
- Other: ______________________

Please list anything else important to understand you/help you (Please consider including hobbies, interests, social life, volunteer work, etc. As well as any ethnic, religious, political or other communities with which you identify, etc.):