Cindy Hatcher
Live Well. Love Deeply. Lead Boldly.

Adolescent Intake Form

Date: _____ Name: _____

Date of Birth: _____ Age: _____ Sex: _____M _____F

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

School: _____ Grade: _____

Race or Ethnicity: ___White ___ Black ___Hispanic/Latin ___Asian ___Other _____

Religious preference: _____ Rate level of faith from 0-10 _____

Part of a Spiritual/Religious Community? Y or N Name: _____

What are your personal goals? _____

_____

_____

Hobbies: _____

List by name the members of your current family in order of their age, beginning with the oldest:

Name	Age	Male or Female	Adjective Describing Them
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Problems Checklist Rating scale: 5 = Major problem 3 = Sometimes a problem 0= Never a problem

_____Never eating/eating too much and/or vomiting to control weight
_____Not able to go to sleep, stay asleep or not awake easily
_____Dealing with how I feel about myself
_____Learning how to trust others
_____Getting along with my parents or other family
_____Worrying about whether I am normal
_____Excessive worry or anxiety
_____Dealing with problems at school
_____Feeling accepted by my peers
_____Feel bad about the way I look/my body
_____Getting a clear sense of what I value
_____Dealing with sexual feeling and/or problems
_____Dealing with drug or alcohol abuse
_____Dealing with how I feel about myself

Disease (Age at onset of problem____)
___No ___Yes If yes, describe: _____
Serious Injury (Age at onset of problem ___)
___No ___Yes If yes, describe: _____
Other Illness or Allergies (Age at onset of problem ___)
___No ___Yes If yes, describe: _____
Have you ever been hospitalized for psychological (incl. drug or alcohol abuse/eating disorder) reasons?
___No ___Yes

Age _____Reason_____ Where_____

Age _____Reason_____ Where_____

Name of primary physician_____

Address & Phone #_____

How long since your last complete physical?_____

For females only: Do you have a regular menstrual cycle? _____On birth control? _____

Have you ever consulted a psychiatrist?
___No ___Yes If yes, explain:_____

Have you ever taken medication for psychological reasons? ___No ___Yes

Name of medication	Dosage	Reason for Treatment

If you have lost someone or something of major importance in the last five years, please specify: _____

Describe why you are here in counseling:

How have you tried to deal with this issue before coming here?

Who helps you the most in your life?

Who do you have the most problems with in your life?

Anything else you want to share or talk about?