Mental Wellness 360*

2500 Willamette Falls Dr. #105,
West Linn, OR 97068

ADOLESCENT INTAKE FORM (ages 12-17)

Adolescent please fill out pages 1-3, parent/guardian please fill out pages 4-8

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female ❒ Other:_____

Phone (Cell): _____Messages okay?___ Text reminder okay?_____

Address: _____City_____State____Zip_____

School: _____ Grade: _____

Please Share electronic communication (FaceBook, Twitter, SnapChat, Instagram, etc) that you use:

_____

Do your parents/guardians have access to your electronic communication? (Y/N) _____Do they have any issues with your use of phone, text, electronic communication? (Y/N) _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? _____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? _____

_____

What would you like to see happen as a result of counseling? _____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

If yes, what did you find **most helpful** in therapy? _____

_____

If yes, what did you find **least helpful** in therapy? _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes, _____No

If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely

If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco or Marijuana? _____Yes, _____No

If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes, _____No

If yes, what drugs do you use? _____

If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go?_____

____Inpatient _____Outpatient

Adolescents (*please answer the following with* **Y/N)**

1. Have you ever used more than 1 chemical at the same time to get high? _____
2. Do you avoid family activities so you can use? _____
3. Do you have a group of friends who also use? _____
4. Do you use to improve your emotions such as when you feel sad or depressed?? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past._____

FAMILY HISTORY

1. Are you adopted or currently in foster care?_____
2. Are your parents married or divorced? _____
3. Do you think their relationship **is** good? (Y/N/Unsure)_____
4. If your parents are divorced, whom do you primarily live with? _____
3. How often do you see each parent? Mom_____% Dad _____%.
4. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.
2. Are you happy with the amount of friends you have? (Y/N)_____
3. Have you ever been bullied? (Y/N) _____
4. Are your parents happy with your friends? (Y/N)_____
5. Are involved in any organized social activities (e.g. sports, scouts, music)? _____
6. Do you consider yourself spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable) _____

_____

_____

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SCHOOL HISTORY

1. Do you like school? (Y/N)_____
2. Do you attend regularly? (Y/N)_____
3. What are your current grades? _____
4. Do you feel you are doing the best you can at School? (Y/N) _____

INDIVIDUAL CONCERNS

SYMPTOM	NONE	MILD	MOD	SEVERE		SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS						APPETITE CHANGES				
CRYING						SOCIAL ISOLATION				
SLEEP DISTRUBANCES						PARANOID THOUGHTS				
PROBLEMS AT HOME						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
BINGING/PURGING						LOW ENERGY				
LONELINESS						EXCESSIVE WORRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRITABILITY						ANGER ISSUES				
NAUSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTALATION						RACING THOUGHTS				
CUTTING						RESTLESSNESS				
IMPULSIVITY						DRUG USE				
NIGHTMARES						ALCOHOL USE				
HOPELESSNESS						EASILY DISTRACTED				
ELEVATED MOOD						TRAUMA FLASHBACKS				
MOOD SWINGS						OBSESSIVE THOUGHTS				
DISORGANIZED						PANIC ATTACKS				
ANOREXIA						FEELING ANXIOUS				
GRIEF						FEELING PANICKY				
PHOBIAS						SUICIDAL THOUGHTS				
HEADACHES						PAST SUICIDE ATTEMPTS				
WEIGHT CHANGES (UNPLANNED CHANGES)						OTHER				

*We would like you to know that we have worked with a lot of adolescents and that we respect your privacy and we hope to create an atmosphere where you feel comfortable sharing. You may give this form to your parent/guardian or you can bring it in yourself.

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Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female ❒ Other:_____

Race/Ethnic Origin: _____

Do you consider your family spiritual or religious? Yes No

Is so, describe your spirituality/faith and you level of participation in a faith-based group (if applicable)

_____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)		Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

_____

What is most concerning right now?

_____

ADOLESCENT'S DEVELOPMENT

1. Was/Is this adolescent in foster care or adopted? Yes ___ No ___ If yes, describe: _____
   _____
2. Were there any complications with the pregnancy or delivery of your adolescent? Yes ___ No ___ If yes, describe:_____
   _____
3. Did your adolescent have health problems at birth? Yes _____ No _____
   If yes, describe:_____
   _____
4. Did your adolescent experience any developmental delays (e.g. toilet training, walking, talking)?
   Yes ___ No ___ Not sure_____
   If yes, describe: _____
   _____
   Did your adolescent have any unusual behaviors or problems prior to age 3? Yes ___ No ___
   Not sure_____ If yes, describe:
   _____
5. Has your adolescent experienced emotional, physical, or sexual abuse?
   Yes ____ No ____ Not sure _____ If yes, describe:_____
   _____

COUNSELING HISTORY

Has your adolescent previously seen a counselor? ❒ Yes ❒ No

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did your son or daughter go to counseling? _____

_____

Does your adolescent have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy?

_____

_____

What did you find **least helpful** in therapy?

_____

_____

Has your adolescent used psychiatric services? Yes____ No____

If yes, who did they see? _____ If yes, was it helpful? N/A____ Yes____ No_____

Has your adolescent taken medication for a mental health concern? Yes_____ No _____

Name of medication	Dates taken	Was it helpful? (Y/N)

Does your adolescent have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe. _____

CHEMICAL USE

Do you have any concerns with your adolescent using alcohol or drugs? (Y/N) _____

If yes, please explain your concern: _____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your adolescent using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern: _____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you, your family, or your adolescent, at present, or past if it has had a significant effect upon you or your adolescent in the past.

_____

_____

FAMILY HISTORY

Are you aware of any birth trauma your adolescent experienced from age 0-3?

_____

_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

_____

_____

PARENT/GUARDIANS MARITAL STATUS

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed ___Other If Divorced please indicate custody agreement: _____

Length of marriage/relationship:_____ If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent? Parent 1_____%, Parent 2 _____%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Parent/Guardian 1_____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship with adolescent, if applicable: Poor_____ Fair_____ Good_____

Parent/Guardian 1_____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Assessment of current relationship with adolescent, if applicable: Poor_____ Fair_____ Good_____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your adolescent is successful when they try? _____

_____

_____

What personal qualities would you say your adolescent has? _____

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your adolescent's life? (Please describe) _____

_____

_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR ADOLESCENT

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGES (UNPLANNED CHANGES)				
SLEEP DISTRUBANCES					PARANOID THOUGHTS				
DISSOCIATION					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/PURGING					LOW ENERGY				
DECREASED SEX DRIVE					EXCESSIVE WORRRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/ INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF MUTALATION					RACING THOUGHTS				
CUTTING					RESTLESSNESS				
IMPULSIVITY					DRUG USE				
NIGHTMARES					ALCOHOL USE				
HOPELESSNESS					DECREASED CREATIVITY				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					WORK ISSUES				
ANOREXIA					PROBLEMS AT HOME				
SOCIAL ISOLATION					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
OBSESSIVE THOUGHTS					FEELING PANICKY				
GRIEF					SUICIDAL THOUGHTS				
HEADACHES					PAST SUICIDE ATTEMPTS				
LONELINESS					OTHER				

Is there anything else you would like to share: _____

_____

_____

Parent Contact Information: Phone_____ Email:_____
Is it ok to leave messages? ____YES ____NO