Adolescent Therapy
INTAKE FORM

Please answer the following questions to the best of your abilities. These questions are to help the therapist with the intake process and remains confidential.

Name:_____

Guardian's Name (if applicable):_____

Birth date: _____/_____/_____ **Age**:_____ **Gender Identification:** _____

Current address:

_____

Phone Number::_____ May we leave a message?
Cell/other: _____ May we leave a message?

Emergency Contact: _____ Relationship:_____

Telephone number_____

Marital status: Never married Partnered Married Separated Divorced Widowed

Names and Ages of Children:_____

Cultural Identity/Religious/Spiritual Information: _____

_____

Highest Level of Education: _____ **School:** _____ **IEP/504?**:_____

Occupational Information:_____

INSURANCE
Primary insurance co & identification number:

_____
Insurance subscriber name and date of birth:
_____

Secondary insurance identification number:
_____
Insurance subscriber name and date of
biirth:_____

Reason for Referral:_____

_____

_____

_____

DEVELOPMENTAL HISTORY:

Are you currently receiving any other mental health services or ever been diagnosed with any mental health conditions? _____

Are you currently taking any psychiatric prescription medication? Yes No
If yes, please list:_____

Have you been prescribed psychiatric prescription medication in the past? Yes No
If yes, please list:_____

Have you been psychiatrically hospitalized in the past? Yes No
If yes, please list dates and
locations:_____

General Health Information

Please provide the name, address and telephone number for your primary care physician:

_____

_____

_____

Childhood Issues (issues during birth, milestones, school aged, head injuries, impulsivity, poor judgment, social issues, traumas):

_____

_____

_____

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, thyroid dysfunction, etc.):

_____

_____

_____

Are you on any medication for physical/medical issues? Yes No
If yes, please list:_____

Are you having any problems with your sleep habits? Yes No
If yes, circle those that apply:
Sleep too much Sleep too little Poor quality Disturbing dreams
Other:_____

Are there any changes or difficulties with your eating habits? Yes No
If yes, circle those that apply:
Eating less Eating more Bingeing Restricting Other:_____

Have you experienced a weight change in the last two months? Yes No

Do you exercise regularly? Yes No

How often do you consume alcohol regularly?
Daily Weekly Monthly Rarely Never

How often do you engage in recreational drug use?
Daily Weekly Monthly Rarely Never
What kinds of substances have you tried:: _____

Have you felt depressed recently? Yes No

Have you had any suicidal thoughts recently? Yes No

Have you ever had suicidal thoughts in your past? Yes No

Have you ever engaged in self-injurious behavior? Yes No

Family Mental Health History, that you suspect or are aware of:

Depression	Yes	No
Anxiety	Yes	No
Suicide Attempts	Yes	No
Bipolar Disorder	Yes	No
Schizophrenia	Yes	No
Alcohol/Substance Abuse	Yes	No

Client to Fill Out this page:

	YES	NO	Details
Depression			
Anxiety			
Suicidal Ideation			
Self- Harm			
Suicide Atttempt			
LGBTQ+			
Bullying			
Fire Setting			
Trauma			
Harm to Animals			
Eating Disorder			
Significant Loss			
Aggression/Fights			
Property Destruction			
History of Neglect/Abuse			
Eating Disorder			
Running Away			
Risky Sexualized Behaviors			
Substance Use			
Family Conflict			
Impulsivity			
Issues with Identity			

What are your goals for therapy/what would you like to accomplish?

_____

_____

_____

_____

By signing below, I am acknowledging that I have chosen to receive mental health services in the form of evaluation and psychotherapy and additional healing services as requested by Better Hope & Healing, LLC. My decision is voluntary and I understand that I may terminate these services at any time. I also understand that during the course of treatment I may need to discuss material of an upsetting nature in order to resolve my problems. Further, I understand it cannot be guaranteed that I will feel better after completion of treatment.

_____ _____

Signature Date

_____ _____

Guardian Signature Date