andrea@envisioncounseling.net | P: 206.858.1177 ext. 136| www.envisioncounseling.net

NEW CLIENT INTAKE FORM

Teenager, 13 years of age and older

To be completed by individual teenage clients to the extent they are able. Please seek parental/guardian assistance when necessary. Please sign and date where indicated.

Name of Teenager_____ DOB __/__/___ Age _____

Gender Pronouns_____

Name of person completing this form: _____

Preferred Phone _____ _ □CellPh □HmPh Other: _____

Email _____ Preferred Communication □Cell □HmPh □Email

Okay to leave a message on my: □ Home □Cell □ Other _____

Residential Address _____ City _____ Zip _____

May I send mail to this address? Yes No

Email _____May I use email to confirm appointments? Yes No

School: _____ Grade: _____

Emergency Contact _____Relationship_____

Phone_____

What is your understanding of why you are participating in therapy?

_____

_____

_____

_____

Have you had any prior counseling or psychiatric treatment? ____ No ___Yes
If yes:

When? _____ Where? _____

Reason for and length of counseling:_____

***Check one*:** **Therapy was ____ helpful ___ not helpful. Please explain:**

_____

_____

_____

_____

MEDICAL / PHYSICAL HEALTH

Name, address and phone number of your primary care physician:

_____

Date of your last physical exam _____

Have you been under a physician's care for any reason in the last five years? If yes, please explain.

_____

_____

_____

_____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU <u>CURRENTLY EXPERIENCE</u>

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____
____Eating disorder	____Obsessive thoughts	

For any of the items checked, please provide additional information regarding your symptoms. How often and severe are your symptoms? Do want to share additional information?

_____

_____

_____

_____

PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU <u>HAVE EXPERIENCED IN THE PAST</u>

____Aggression	____Fatigue	____Panic attacks
____Alcohol use	____Flashbacks	____Phobias/fears
____Anger	____Grief	____Poor judgment
____Anxiety	____Hallucinations	____Self-esteem problems
____Chronic pain	____Heart palpitations	____Sexual difficulties
____Compulsive behavior	____High blood pressure	____Sleep problems
____Concentration problems	____Hopelessness	____Social withdrawal
____Cyber addiction	____Hyperactivity	____Suicidal thoughts
____Depression	____Impulsivity	____Thoughts disorganized
____Disorientation	____Irritability	____Trembling
____Distractibility	____Loneliness	____Unresolved trauma
____Dizziness	____Memory impairment	____Worrying
____Drug dependence	____Mood swings	____Other (specify):_____
____Eating disorder	____Obsessive thoughts	

For any of the items checked, please provide additional information. When did you experience these symptoms? Can you identify a cause of your symptoms? How often and severe were your symptoms? If the symptoms stopped, can you identify why they did so?

_____

_____

_____

_____

Alcohol and Substance Use

Have you ever been treated for alcohol or drug dependence/abuse?
__Yes __No

Have you ever felt like you should cut down on alcohol or other drug use?
__Yes __No

Has a friend or relative ever discussed concerns about your alcohol or drug use?
__Yes __ No

Is there a history of problems with alcohol or drug use in your family?
__Yes __ No

Have you received help for drug or alcohol dependency? ___ No ___Yes
If yes,

When? _____ **Where**?_____

***Check one*:** **Treatment was ___ helpful ___ not helpful. Please explain.**

_____

_____

_____

_____

MEDICATION

Current Prescribed Medications	Dose	Frequency	Purpose and Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please describe your experience growing up in your family. Describe your relationship with your parents and siblings. What is your birth-order position in the family?

_____

_____

_____

_____

What is your role in your family?

_____

_____

_____

_____

What stories about you are told in your family?

_____

_____

_____

_____

Please describe your medical history.

_____

_____

_____

_____

Please describe your mental health history.

_____

_____

_____

_____

Please describe your developmental history. Did you struggle with meeting developmental timelines or a learning difficulty? If so, is this still a problem for you?

_____

_____

_____

_____

How well do you perform academically? How do you feel about this level of performance?

_____

_____

_____

_____

Have you struggled with behavior problems? Do you act in ways that cause you problems currently? If so, please explain.

_____

_____

_____

_____

Please describe your social behaviors and history of social relationships. Do you make friends easily? Do you struggle with peer relationships?

_____

_____

_____

_____

Have you experienced trauma? If so, please describe.

_____

_____

_____

_____

Who do you do you go to when you feel upset?

_____

_____

_____

_____

What are your strengths?

_____

_____

_____

_____

What are your challenges?

_____

_____

_____

_____

What activities do you do for fun?

_____

_____

_____

_____

What do you do to relax and/or care for yourself?

_____

_____

_____

_____

What stresses you out?

_____

_____

_____

_____

How do you cope with stress?

_____

_____

_____

_____

If you had three wishes for yourself, what would they be?

_____

_____

_____

_____

If your three wishes came true, how would you know? What would be different?

_____

_____

_____

_____

What prompted your family to seek therapy?

_____

_____

_____

_____

How do you think each family member contributes to the problem?

_____

_____

_____

_____

If the problem was resolved, how would you know? What would be different?

_____

_____

_____

_____

Please describe your family's strengths.

_____

_____

_____

_____

Please describe your family's challenges.

_____

_____

_____

_____

What would you like to be different in your family?

_____

_____

_____

_____

Is there anything else you think would be helpful for me to know about you or your situation?

_____

_____

_____

_____

By signing below, I confirm the information I provided on this document to be complete and truthful to the best of my knowledge.

_____	_____	_____
Client Name (please print)	**Signature of Client (or authorized representative)**	**Date**

_____	_____	_____
Information (please print) Also Provided by	**Signature**	**Date**