Abundant Life
COUNSELING SERVICES, P.A.

ADOLESCENT INTAKE FORM FOR ADOLESCENT

Thank you for choosing Abundant Life Counseling Services, P.A. This form is for you, the adolescent, to fill out. I want you to give me all the information you want me to know. It will allow me to better assist you. Please be as open as you can in giving me information. If you are unsure of something, you can skip it and we can talk about it later. All information is held in strictest confidence within legal limits. If certain questions do not apply to you, please leave them blank.

IDENTIFYING INFORMATION

Your Full Name _____Nick Name _____

Date of Birth _____ Present Age _____ Male _____Female _____

School Attending _____

Name of Parents/Guardians _____

Your Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

May we call you at your home? Yes _____ No _____

May we call you on your cell phone? Yes _____ No _____

May we leave a message at home? _____ On your cell? _____

Do you attend church regularly? Yes _____ No _____

Are religious or spiritual issues important in your life? Yes _____ No _____

Name and denomination of your church _____

HEALTH INFORMATION

How would you rate your health? _____

Recent (3 months) weight change: Lost _____ lbs. Gained _____ lbs.

List all important present or past illnesses, injuries or handicaps: _____

_____

How many hours do you sleep each night? _____

Do you experience food cravings? Yes _____ No _____

If so, for what items? _____

How would you rate your diet?

Very Healthy _____ Healthy _____ Average _____ Needs Improvement _____ Poor _____

Are you currently on medications? Yes _____ No _____ If yes, please list what you know you are taking: _____

Adolescent girls:

Are you pregnant? Yes _____ No _____ Unsure _____

Do you have a regular menstrual cycle? Yes _____ No _____ Not of age _____

Have you ever terminated a pregnancy? Yes _____ No _____

Have you ever miscarried? Yes _____ No _____

PERSONAL CONCERNS

Do you have any concerns about yourself?

_____

_____

_____

Do you do things you wish you could change? _____

_____

_____

What do you believe your three greatest strengths are?

1) _____

2) _____

3) _____

What do you believe your three greatest weaknesses or areas of improvement are?

1) _____

2) _____

3) _____

PROBLEMS CHECKLIST

Rate each issue with a number: 1=Major Problem 2=Problem at times 3=Not a problem

_____ Feeling accepted by my peers/friends
_____ Learning how to trust others
_____ Getting along with my parents
_____ Getting along with my siblings
_____ Getting along with other family members
_____ Getting a clear sense of what I value

Rate each issue with a number: 1=Major Problem 2=Problem at times 3=Not a problem

_____ Dealing with sexual feelings and/or problems
_____ Worrying about my future
_____ Trying to decide on a career
_____ Dealing with alcohol
_____ Dealing with drugs
_____ Dealing with problems at school
_____ Dealing with how I feel about myself
_____ Thinking I want to die

Additional problems I'd like to talk about: _____

_____

_____

_____

Have you been to counseling before? Yes _____ No _____

When and what for? _____

How did it go? _____

FAMILY HISTORY

Mother's Name _____

Father's Name _____

If your parents are separated or divorced, how old were you when this happened?

_____

Who do you currently live with? _____

What is their relationship to you? _____

SOCIAL DEVELOPMENT AND PEER RELATIONSHIPS

What special interests, hobbies, sports, and games do you enjoy, both in and after school?

_____

_____

Do you have at least one best friend? Yes _____ No _____

What is the friend's age? _____

Please give any additional information that you believe would be helpful for me to know

_____

_____

_____

_____