ADOLESCENT INTAKE FORM Today's Date: ______________

Adolescent's Name: (First) (MI) (Last)

Birthdate: __________ Gender:

Age: _________ F M Other

Parent's Work Phone: ______________________________

Parent's Work Phone: ______________________________

Home/Cell Phone: ______________________________

Home/Cell Phone: ______________________________

Parent's Name: ______________________________ Age: Occupation: ______________________________ Educational Level: ______________

Parent's Name: ______________________________ Age: Occupation: ______________________________ Educational Level: ______________

Legal Guardian: ______________________________

Adolescent Currently Lives With:

Step-Parent(s) (if applicable): ______________________________

Name of person completing form: ______________________________

Please give a brief description of why you are seeking treatment:

____

Who referred you to our clinic?

____

FAMILY AND SOCIAL HISTORY

Adolescent's Siblings:	Age	Sex	Grade	Adolescent's Siblings:	Age	Sex	Grade

Adolescent's Siblings:	Age	Sex	Grade	Adolescent's Siblings:	Age	Sex	Grade

Is the teen or any siblings adopted? Yes No

List all members living in the household:

____

____

If applicable give date(s) of adolescent's parents' marriage, separation(s), and/or divorce:

____

____

Describe any family history of mental health or chemical dependency problems or treatment:

____

____

Has any other member of the family ever been seen for services through BHSI? Yes No

If so, when? ______________________ Which family members were seen? ____

List any involvement with social services, child protection, the court system or legal services:
____

Has there been any physical, emotional or sexual abuse? Yes No

SCHOOL HISTORY

Name of current school: ____ Grade: _____________

Schools attended: Elementary ________________________ Junior/Middle: ____________________________

List any special services received in schools and the grade level in which they were received: _______________________

Does this teen have a job outside of school? Yes No

DEVELOPMENTAL HISTORY

Were there any problems in pregnancy, labor, birth or delivery with this adolescent? Yes No

If yes, please give details: ____

Have there been any concerns or delays with development in any of the following areas? If yes, please indicate who evaluated the problem if help was sought.

				Evaluated By:
1.	Speech & Language	Yes	No	______________________
2.	Hearing	Yes	No	______________________
3.	Vision	Yes	No	______________________
4.	Intelligence/ability to learn	Yes	No	______________________
5.	Bladder/Bowel Control	Yes	No	______________________
6.	Emotional/Maturity Level	Yes	No	______________________
7.	Social Skills	Yes	No	______________________
8.	Eating Habits	Yes	No	______________________
9.	Fine Motor Skills (writing, coloring, etc.)	Yes	No	______________________
10.	Gross Motor Skills (walking, running, etc.)	Yes	No	______________________

4. MEDICAL HISTORY

Primary Care Clinic: ____________________ Physician: ____________________

Date of last medical examination: ____________________

Current medical problems: ____________________

List any hospitalizations or serious medical problems: ____________________

Current medications: ____________________

List any medications previously prescribed/taken: ____________________

List any drug allergies: ____________________

Have there been any pregnancies, miscarriages, abortions? ____________________

Do we have your permission to contact your primary care provider to assist with coordination of your care? Yes No

5. CHEMICAL USE HISTORY

Drug Name	Use Currently	Used within last 12 months	Have used in past	Never
Cannabis—Marijuana, Hash				
Alcohol				
Amphetamines—Speed, Cocaine, Crack, Crank, Dexedrine, White Crosses, Ritalin, Cylert, etc.				
Tranquilizers—Valium, Xanax, Ativan, Librium, Quaaludes, etc				
Narcotics—Codeine, Darvon, Demerol, Morphine, Heroin, Methadone, Etc.				
Other—Inhalants, PCP, LSD, Mushrooms, Paint Thinner, Glue, etc.				

Have you used more than one chemical at the same time in order to get high? Yes No

Do you avoid family activities so you can use? Yes No

Do you have a group of friends who also use? Yes No

Do you use to improve your emotions, such as when you feel sad or depressed? Yes No

Do you use tobacco products? Yes No If yes, type: ____________ Quantity per day: ________

Do you use caffeine? Yes No If yes, type: ____________ Quantity per day: ________

6. PREVIOUS TREATMENT

List any counselors seen in the past and reason for visits: ____

____

List dates of any psychiatric hospitalizations: ____

____

7. **ADOLESCENT PROBLEM CHECKLIST**

Please check if you have been experiencing any of the following symptoms/behaviors currently or over the past month.

Sadness	Big changes in friends
Crying easily	Blowing up about little things
Loss of interest or pleasure in activities	Getting into physical fights
Concerns about eating	Not following rules at home or school
Weight loss or gain	Bothered by adults or teachers
Decrease or increase in appetite	Problems with friends
Uncontrolled eating or dieting	Trouble falling or staying asleep
Excessive use of laxatives	Irritable, angry feelings, crabby
Tired a lot	Fears, worries, or anxieties
Don’t like myself much	Excessive energy
Caring less about personal appearance	Lying , stealing , destruction of property
Difficulty concentrating	More arguments with others
Want to hurt myself	Fighting with siblings
Thoughts of harming others	Family problems
Thoughts of death	Nightmares
Panic attacks	Relationship problems
Nervousness	Problems with parents
A lot of aches or pains	Engage in physically dangerous activities
Sexual concerns	Impulsive/ excitable
Problems at school	Inattentive, easily distracted
Not doing homework	Restless, fidget excessively
Skipping school/ classes	Unusual habits or compulsive behaviors

Anything else you want us to know?