THE CENTER
for Creative Arts and Play Therapy

Adolescent Intake Form

Client Information

Name:

Date of Birth: | Today's Date:

Phone #: | Email:

Is it ok to leave messages at this phone number? ☐ Yes ☐ No May we contact you via email? ☐ Yes ☐ No

Emergency Contact Name: | Phone #:

SEX ASSIGNED AT BIRTH: ☐ Female ☐ Male ☐ Intersex ☐ Prefer not to disclose

Gender: ☐ Prefer not to disclose

Sexual Orientation: ☐ Prefer not to disclose

Race: ☐ Prefer not to disclose

Family Information

Parent: | Age: | Lives with you? ☐ Yes ☐ No

Parent: | Age: | Lives with you? ☐ Yes ☐ No

PARENTS' MARITAL STATUS: ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ _____

Step-parent? | Step-parent?

Do you have siblings? ☐ Yes ☐ No If no, please skip to the next section.

Name: | Age: | Lives with you? ☐ Yes ☐ No

Name: | Age: | Lives with you? ☐ Yes ☐ No

Name: | Age: | Lives with you? ☐ Yes ☐ No

Additional household members:

Family History

Please describe your relationship with your parents/caregivers:

Please describe the relationship between your parents/caregivers:

Please list any additional family members who are significant, as well as any pets:

If there is anything from your childhood that you'd like to share, please do so here:

Support System

Do you have a support system? ☐ Yes ☐ No

Who can you turn to when you need help?

Friendships (Number, quality, etc.):

Dating history:

Is your home environment safe? ☐ Yes ☐ No

If no, please explain:

Are there firearms in the home? ☐ Yes ☐ No If yes, how are they stored?

Employment/Education Status

School: Grade:

What are your highest and lowest grades?

Are there any discipline concerns?

Are you employed anywhere?

Mental Health History

Have you experienced any of the following in the past 90 days or have a history of being diagnosed with any of the following at any time? Please check all that apply:

- ☐ ADHD
- ☐ Anger/Rage
- ☐ Anxiety/Social Anxiety
- ☐ Dementia
- ☐ Depression/Bipolar Disorder
- ☐ Eating Disorder
- ☐ Hallucinations
- ☐ Other: _____
- ☐ Hospitalization
- ☐ Learning Disorder
- ☐ Obsessive/Intrusive Thoughts
- ☐ Mood Swings
- ☐ Panic/Phobia
- ☐ Paranoia/Delusions
- ☐ Poor Sleep Patterns
- ☐ PTSD
- ☐ Racing Thoughts
- ☐ Self Injury/Harm
- ☐ Substance Use Disorder
- ☐ Thoughts of Harming Others
- ☐ Thoughts of Suicide
- ☐ Violence
- ☐ Weight Gain/Loss

Have you experienced any kind of abuse or trauma? ☐ Yes ☐ No

If yes please explain:

Have you ever been admitted to the hospital for mental health reasons? ☐ Yes ☐ No

If yes please explain:

Is there any family history of mental health problems or suicide (attempts)? ☐ Yes ☐ No

If yes please explain:

Have you seen a psychiatrist/therapist in the past? ☐ Yes ☐ No If yes, was it helpful? ☐ Yes ☐ No

Previous provider(s):

Dates seen:

Stressors

What stressors are you dealing with or have you dealt with in the past? Please check all that apply:

- ☐ Alcohol/Drug Use
- ☐ Attempted Suicide
- ☐ Death
- ☐ Injuries/Disabilities
- ☐ Parent Conflict
- ☐ Financial Crisis
- ☐ Frequent Moves
- ☐ Legal Problems
- ☐ Physical/Sexual Abuse
- ☐ Psychiatric Illness
- ☐ Serious illness
- ☐ Other _____

Medical History

Are you currently taking any medications? ☐ Yes ☐ No

Name(s)/Dosage:

Do you have any health conditions, injuries, or recent hospitalizations? ☐ Yes ☐ No

If yes, please list symptoms and treatments you are undergoing:

Do you have any allergies? ☐ Yes ☐ No

If yes, please list:

Do you have a history of head injury or seizure? ☐ Yes ☐ No

If yes, please explain:

Do you experience physical pain that causes mental health issues? ☐ Yes ☐ No

Health care providers, including PCP and prescribers:

Personal History

What symptoms are you dealing with? Please check all that apply:

- ☐ Appetite Problems
- ☐ Concentration Problems
- ☐ Energy Levels
- ☐ Flashbacks
- ☐ Hopelessness
- ☐ Low Interest/Motivation
- ☐ Mood Swings
- ☐ Nightmares
- ☐ OCD Symptoms
- ☐ Panic Attacks
- ☐ Self-harm/Suicidal Thoughts
- ☐ Trouble Sleeping
- ☐ Other _____

How frequently do you deal with these difficulties?

What effect do these have on your life? ☐ Minimal ☐ Mild ☐ Moderate ☐ Severe

How long have these difficulties persisted?

Habits & Lifestyle

Do you drink alcohol, use tobacco, or vape? ☐ Yes ☐ No

If yes, amount and how often:

Are you dealing with any addictions? ☐ Yes ☐ No

If yes, please explain:

How often do you engage in recreational drug use?

☐ Never ☐ Rarely ☐ Monthly ☐ Weekly ☐ Daily

Do you consider your alcohol/drug use a problem? ☐ Yes ☐ No ☐ Unsure

Do you exercise regularly? ☐ Yes ☐ No

If yes, please describe what you do and how often:

List your strengths, hobbies and interests:

Any spiritual beliefs or cultural beliefs important to you:

Have you dealt with or are you dealing with any legal issues? ☐ Yes ☐ No

If yes, please explain:

Have you ever been imprisoned? ☐ Yes ☐ No

If yes, please explain:

Are you court ordered for services? ☐ Yes ☐ No If no, please skip to the next section.

Are you assigned to a probation officer or case worker? ☐ Yes ☐ No

If yes, please list them here:

Name: Phone Number:

Will you require progress reports for legal authorities? ☐ Yes ☐ No

Goal Information

Please answer the following questions to the best of your ability:

Why are you seeking treatment at this time?

What would you like to change about yourself or your circumstances?

What gives you hope, purpose, and meaning?

What do you hope to get from treatment?

By signing below, I agree that I have completed this form to the best of my ability and knowledge. I agree to inform the therapist of any changes in the above information.

Printed Name Signature Date