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**Adolescent Intake Questionnaire (ages 12-17)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Answer the questions you feel comfortable, and leave those you don’t want to answer blank😊

Name: [ ]

Date of Birth: [ ] Age: [ ] Male Female

Phone: [ ] Messages okay? yes no

School: [ ] Grade: [ ]

**PERSONAL STRENGTHS:**

What activities do you enjoy and feel you are successful when you try? [ ]

Who are some of the supportive people in your life? [ ]

**CURRENT REASON FOR SEEKING COUNSELING:**

Briefly describe the problem for which you are seeking to have counseling for? [ ]

What would you like to see happen as a result of counseling? [ ]

**COUNSELING/THERAPY HISTORY**:

Have you previously seen a counselor? Yes No

If yes, what did you find most helpful in therapy? [ ]

If yes, what did you find least helpful in therapy? [ ]

**CHEMICAL USE AND HISTORY**:

Do you currently use any alcohol or drugs? Yes, No

If yes, what drugs do you use? [ ]

If yes, how often do you use? Daily, Weekly, Occasionally, Rarely

Have you received any previous treatment for chemical use? Yes, No

If so, where did you go? [ ]

1. Have you ever used more than 1 chemical at the same time to get high? Yes, No

2. Do you avoid family activities so you can use? Yes, No

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

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

**FRIENDS/PEERS:**

1. How do you consider yourself socially: outgoing shy depends on the situation.

2. Are you happy with the amount of friends you have? Yes, No

3. Have you ever been bullied? Yes, No

4. Are you involved in any social activities and if so, which ones? [ ]

**SCHOOL HISTORY:**

1. Do you like school? Yes, No

2. Do you go regularly? Yes, No

3. What kind of grades do you get? Yes, No

**Current concerns (please check Yes or No for each one below)**

**YES NO YES NO**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Sadness |  |  |  | Alcohol use |  |  |
| Crying |  |  |  | Easily distracted |  |  |
| Sleeping problems |  |  |  | Flashbacks |  |  |
| Problems at home |  |  |  | See things others can’t see |  |  |
| Problems at school |  |  |  | Hear things others can’t hear |  |  |
| Lonliness |  |  |  | Obsessive thoughts |  |  |
| Irritability or feeling crabby |  |  |  | Panic attacks |  |  |
| Stomach pain |  |  |  | Feeling anxious |  |  |
| Headaches |  |  |  | Feeling panicky |  |  |
| Hurting self |  |  |  | Suicidal thoughts |  |  |
| Nightmares |  |  |  | Past suicidal attempts |  |  |
| Anger |  |  |  | Weight/appetite changes |  |  |
| Poor concentration |  |  |  | Friendship problems |  |  |
| Low energy |  |  |  | Other: [ ] |  |  |
| Worry a lot |  |  |  | Other: [ ] |  |  |
| Drug use |  |  |  | Other: [ ] |  |  |

Thank you 😊