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

**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 😊