Palm Beach Family Therapy
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ADOLESCENT INTAKE FORM

To Be Filled In By The Adolescent

CLIENT INFORMATION

Name:

____

Date of Birth: _________________________________ Age: _______ Gender:______________

Phone (Cell): _________________________Can I leave messages at this number? ❒ Yes ❒ No

Address:____
____

School: ____Grade:___________________

CURRENT REASON FOR SEEKING THERAPY

Why are you coming to therapy?

____
____
____

How are you thinking therapy might help you?

____
____
____

PERSONAL STRENGTHS

What activities do you enjoy?

____
____
____

What qualities are you proud to share with others? (e.g. kindness, intelligence)

____
____
____

THERAPY/TREATMENT HISTORY

Have you previously seen a therapist? ❒ Yes ❒ No

If yes, who did you work with?____

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

____
____
____

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

____
____
____

SUBSTANCE USE AND HISTORY

Do you currently drink alcohol? ❒ Yes ❒ No

If yes, how **often** do you drink? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

If yes, how **much** do you drink? ____________(#) per time.

Do you currently use tobacco? Vape? ❒ Yes ❒ No

If yes, how **often** do you smoke/vape/ chew? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

Do you currently use any other drugs? ❒ Yes ❒ No If yes, what kind?

____

____

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

FAMILY INFORMATION

Are your parents married, divorced or separated: ❒ Married ❒ Divorced ❒ Separated
Do you think their relationship is good? ❒ Yes ❒ No ❒ Unsure
If your parents are divorced, whom do you primarily live with? Please describe the living/custody arrangements:

____

____

____

Have either or your parents remarried (or are currently living with someone?) Please describe the living circumstances. (Who lives in which house, and which days? Are there other children living in this home?)

____

____

____

Were you adopted? ❒ Yes ❒ No

FAMILY CONCERNS *Please check any family concerns that your family is currently experiencing*

- ❒Fighting ❒ Disagreeing about relatives ❒ Feeling distant
- ❒Disagreeing about friends ❒ Loss of fun ❒ Alcohol use
- ❒ Lack of honesty ❒ Drug use ❒ Physical fights ❒ Education problems
- ❒Divorce/separation ❒ Financial problems ❒ Issues regarding remarriage and children from another family ❒ Death of a family member ❒ Birth of a sibling ❒ Abuse/neglect ❒ Birth of a child
- ❒Inadequate housing

Please give more information about the above or add other concerns not listed above:

____

____

____

PEER RELATIONS

How do you consider yourself socially? ❒ Outgoing ❒ Shy ❒ Depends on the situation

Are you happy with the amount of friends you have? ❒ Yes ❒ No

Have you ever been bullied? ❒ Yes ❒ No If yes, please describe:

____

____

____

Are your parents happy with your friends? ❒ Yes ❒ No

Are there other concerns about friendships you would like to discuss?

____

____

____

Are you involved in any organized social activities? (e.g. sports, music)?

____

____

____

SCHOOL HISTORY

On a scale of 1-10 (10 being the most) how much do you enjoy school?

____

Do you attend regularly? ❒ Yes ❒ No

Generally, how are your grades?

____

Have there been any significant changes in your grades? ❒ Yes ❒ No

Do you feel you are doing the best you can at school? ❒ Yes ❒ No ❒ Unsure

INDIVIDUAL CONCERNS

Is there anything else you would like to share?

____

____

____

Please answer the following about how you may be feeling, selecting one the following descriptions: Mild, Moderate, Severe, None.

Social Anxiety ❒ Mild ❒ Moderate ❒ Severe ❒ None

Sadness/ Social Isolation ❒ Mild ❒ Moderate ❒ Severe ❒ None

Crying ❒ Mild ❒ Moderate ❒ Severe ❒ None

Paranoid or suspicious Thoughts ❒ Mild ❒ Moderate ❒ Severe ❒ None

Problems at Home ❒ Mild ❒ Moderate ❒ Severe ❒ None

Indecisiveness ❒ Mild ❒ Moderate ❒ Severe ❒ None

Hyperactivity ❒ Mild ❒ Moderate ❒ Severe ❒ None

Low Energy ❒ Mild ❒ Moderate ❒ Severe ❒ None

Binging/Purging ❒ Mild ❒ Moderate ❒ Severe ❒ None

Excessive Worry ❒ Mild ❒ Moderate ❒ Severe ❒ None

Loneliness ❒ Mild ❒ Moderate ❒ Severe ❒ None

Poor Concentration ❒ Mild ❒ Moderate ❒ Severe ❒ None

Guilt ❒ Mild ❒ Moderate ❒ Severe ❒ None

Low Self Worth ❒ Mild ❒ Moderate ❒ Severe ❒ None

Irritability ❒ Mild ❒ Moderate ❒ Severe ❒ None

Anger Issues ❒ Mild ❒ Moderate ❒ Severe ❒ None

Identity Questions ❒ Mild ❒ Moderate ❒ Severe ❒ None

Nausea/Indigestion ❒ Mild ❒ Moderate ❒ Severe ❒ None

Social Anxiety ❒ Mild ❒ Moderate ❒ Severe ❒ None

Feeling Anxious ❒ Mild ❒ Moderate ❒ Severe ❒ None

Panic ❒ Mild ❒ Moderate ❒ Severe ❒ None

Headaches ❒ Mild ❒ Moderate ❒ Severe ❒ None

Fears ❒ Mild ❒ Moderate ❒ Severe ❒ None

Grief/Sadness ❒ Mild ❒ Moderate ❒ Severe ❒ None

Hopelessness ❒ Mild ❒ Moderate ❒ Severe ❒ None

Suicidal thoughts ❒ Mild ❒ Moderate ❒ Severe ❒ None

Self harm/ Cutting ❒ Mild ❒ Moderate ❒ Severe ❒ None

Mood Swings ❒ Mild ❒ Moderate ❒ Severe ❒ None

Racing thoughts ❒ Mild ❒ Moderate ❒ Severe ❒ None

Obsessive Thoughts ❒ Mild ❒ Moderate ❒ Severe ❒ None

Trauma ❒ Mild ❒ Moderate ❒ Severe ❒ None

Impulsivity Restlessness ❒ Mild ❒ Moderate ❒ Severe ❒ None

Nightmares ❒ Mild ❒ Moderate ❒ Severe ❒ None

Anorexia/ Change in Weight (loss or gain) ❒ Mild ❒ Moderate ❒ Severe ❒ None

Change in Appetite ❒ Mild ❒ Moderate ❒ Severe ❒ None

Difficulty Sleeping ❒ Mild ❒ Moderate ❒ Severe ❒ None

Thoughts of Hurting Someone ❒ Mild ❒ Moderate ❒ Severe ❒ None

Other Not Mentioned:

____

____

____

Please print and sign your name below:

CLIENT PRINTED NAME:

____

CLIENT SIGNATURE:

____

DATE:

____/____/____