**Sacred Space Counseling Center DFW**
**800 Airport Freeway, Suite 745**
**Irving, Texas 75062**

# Adolescent Intake (ages 12-17)

## CLIENT INFORMATION

Legal Name: _____

Preferred Name: _____

Please circle one: MALE FEMALE TRANSGENDER

Date of Birth / Age: _____ Social Security: _____

Home Phone: _____ Parent's Cell Phone: _____

Parent's Work Phone: _____

Home Address: _____

City: _____ Zip: _____

Phone: _____

Please circle where we may leave a voice message: HOME WORK CELL

May we contact you by email? Yes _____ No _____ If yes, please provide email: _____

May we contact you by text message? Yes _____ No_____

*I understand that while an email or text is confidential, there is no way for us to ensure the privacy from third parties. Due to the possibility that private information might be intercepted, please sign below for your permission for us to contact you via text/email for appointments only. We will not discuss clinical information by these mediums.*

If you desire to receive communication about appointments by text or email, initial here. _____

If we have your permission to mail information to your home address, please initial here. _____

Please list the names/ages or all occupants that currently reside in your home:

_____

_____

_____

## CAREGIVER / PARENT INFORMATION

(1) Caregiver/Parent Name: _____ Age _____

Single____ Married ____ Partnered ____ Divorced____ Engaged____ Separated____ Widowed_____

Name of Spouse/Significant Other: _____ Age _____

Length of time together: _____ years _____ months

(2) Caregiver/Parent Name: _____ Age _____

Single____ Married ____ Partnered ____ Divorced____ Engaged____ Separated____ Widowed_____

Name of Spouse/Significant Other: _____ Age _____

Length of time together: _____ years _____ months

If divorced or separated, please tell us the Custody Status:

_____

_____

Emergency Contact: _____

_____

WHAT IS THE MOST PRESSING CONCERN YOU HAVE FOR YOUR ADOLESCENT AT THIS TIME:

_____

_____

**PRESENTING PROBLEM FOR CAREGIVER / PARENT**

Please place an "X" beside stressors you have had in recent months:

__Marital Issues __Health Issues __Job Issues __Financial Issues
__Parent/Adolescent Issues __Issues in past Other: _____

**ADOLESCENT'S PRESENTING PROBLEM** * Please place an "X" beside all that apply.

| | | | | |
|---|---|---|---|---|
| __Sexual abuse | __Physical abuse | __Neglect | __Nightmares | __Suicidal thoughts |
| __Sexually acting out | __Shyness | __Sleeping issues | __Anxiety | __Academic issues |
| __Change in appetite | __Concentration | __Bed wetting | __Stealing | __Clinging behavior |
| __Impulsivity | __Temper outbursts | __Withdrawn | __Lying | __Peer conflict |
| __Drug use | __Stubborn | __Running away | __Missing school | __Health issues |
| __Strange thoughts | __Legal trouble | __Harming self | __Head banging | __Overactive |
| __Skipping school | __Grief | __Sexual problems | __Fearful | __Aggression |

Other problems and/or concerns:

_____

_____

How long have these problems occurred (number of weeks, months, years) _____

**EDUCATIONAL INFORMATION**

Does your adolescent attend school? Yes _____ No _____
If yes, what school do they attend? _____
What grade are they in? _____
Does your adolescent receive any special educational services through the school (e.g.: Special Education, Resource, ESL)? Yes _____ No _____
If yes, please describe the type of special services received: _____

**HEALTH INFORMATION**

Please rate your adolescent's health:
Very good _____ Good _____ Average _____ Declining _____
Recent Weight Changes: Yes _____ No _____ N/A _____
List any present or past illnesses or injuries:

_____

_____

Is your adolescent currently taking any medications: Yes _____ No _____
If yes, please list any current medications:

_____

_____

Is your adolescent currently being treated for any medical conditions? Yes _____ No _____
Is your adolescent currently using any substances for other than medical purposes? Yes _____ No _____
If so, please list:

_____

_____

**MENTAL HEALTH INFORMATION**

Has your adolescent previously received psychotherapy or counseling? Yes _____ No ____
If yes, please list the counselor and approximate dates: _____

_____

_____

Please briefly describe your experience (was it effective/outcome):

_____

_____

Is your adolescent currently receiving any mental health services? Yes _____ No _____
If yes, please list the name of the practitioner and the type of service you are receiving:

_____

_____

Is there any history of psychiatric illness in your family? Yes _____ No _____
If yes, please list the type and relationship: _____
Has your adolescent ever received a psychiatric diagnosis? Yes _____ No _____
If yes, please list: _____
Has your adolescent ever or are they currently engaged in self-harming behaviors? Yes _____ No _____
Has your adolescent ever or are they currently having thoughts of hurting themselves? Yes _____ No _____
Is your adolescent currently having issues with sleep? Yes _____ No _____
If so, please describe: _____

_____

Is your adolescent currently experiencing any changes in his/her appetite? Yes _____ No _____
If so, please explain: _____
Briefly describe what circumstances encouraged you to seek counseling for your adolescent at this time:

_____

_____

_____

**YOUR ADOLESCENT'S STRENGTHS**

Which activities does your adolescent most enjoy?

_____

_____

What personal qualities do you most appreciate in your son or daughter?

_____

_____

Who are some of the influential and supportive people in your son or daughter's life?

_____

_____

Does your adolescent consider himself/herself spiritual? Yes _____ No _____

Please describe some of your adolescent or family's guiding beliefs:

_____

_____

**SPECIAL CONFIDENTIALITY NOTICE FOR PARENTS**

Your adolescent has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your adolescent to do so. We need him/her to be open and honest with us in order to understand and treat the full range of potential issues, and he/she may be too scared, angry, or ashamed right now to share those issues with you.

We also recognize it is very important for you to know what your adolescent is going through in order to do your job as a parent, which is why we will always encourage him/her to be honest with you. We will encourage, prepare and support your adolescent so that they feel safe enough to share those issues with you.

I certify that the information contained in these forms is true and I have the legal right to make decisions regarding my adolescent's mental health treatment. I will provide the therapist with documentation regarding my custody status, if applicable.

By signing below, I am giving consent for psychotherapeutic treatment for my adolescent.

_____ _____

Printed Name Date

_____ _____

Parent Signature Date