Name:_______________________________________

POSITIVE CHOICES COUNSELING SERVICES- ADOLESCENT INTAKE

Date:________________ Pharmacy: _____________________ Other Insurance: __________________________

Name:____ Age: _________ DOB: ______________________

SSN: _____________________________________ Medicaid ID: ____

Medicaid: Address: ____________________________________ City/State/Zip: ____________________________

Physical Address: ____ City/State/Zip: ___________________________

Phone Number: ____ Is it okay to leave a message? _______________

Name and relationship of person bringing in client: ____

Referred by: _____________________________________ Relationship: ____________________________________

Name of client's parents: ____

Parents' marital status: **Single** **Engaged** **Married** **Divorced** **Separated**

Living Together **Remarried** **Widowed**

Parents' Occupations: ____

Emergency contact: _______________________________ Phone Number: ___________________________________

People who currently live in child/adolescent's household:

Name	**Sex**	**Age**	**Relationship**

Reason for seeking help at this time: ____

____

Significant people or family members **not** currently living with child/adolescent:

Name	**Sex**	**Age**	**Relationship**

Name:____

Please circle each item which is a concern to you or your child/adolescent about him/her:

Appetite/Weight	Stomach ache	Health problems	Feeling inferior
Bowel problems	Headaches	Sleep- too little/ too much	Shyness
Depression	Loneliness	Suicidal thoughts	Making decisions
Low energy	Unhappiness	Tiredness	Work
Career	Ambition	Concentration	Education
Difficulty relaxing	Anger	Temper	Self control
Children	Discipline	Being a parent	Nervousness
Stress	Fears	Legal matters	Finances
Friends	Nightmares	Dreams	Memories
Thoughts	Alcohol use	Drug use	Separation
Marriage	Sexual problems	Moves	Deaths
Physical abuse	Sexual abuse	Verbal abuse	Neglect
Visitation/custody	Other changes: ____		

Circle symptoms your child has and number of times per week:

____ Anxiety	____ Anger	____ Overeating	____ Acts our sexually with others
____ Bedwetting	____ Defiance	____ Under eating	____ Masturbates excessively
____ Day wetting	____ Controlling	____ Sleeplessness	____ Unusual/excessive sexual knowledge
____ Day pooping	____ Lack of empathy	____ Nightmares	____ Plays out sexual themes
____ Obsesses	____ Lying	____ Hyper vigilance	____ Plays out violent themes
____ Depression	____ Low impulse control	____ Startles easily	____ Homicidal themes/actions
____ Low energy	____ Stealing	____ Fears/Phobias	____ Suicidal thoughts/actions
____ Shy	____ Drug/alcohol use	____ Running away	____ Stomach aches/headaches
____ Tantrums	____ Peer problems	____ Spacing out	____ Impaired conscience
____ Violent	____ Excessive crying	____ Low concentration	____ Feelings of inferiority
____Grief	____Putting self down	____Memories	____Academic problems
____Allergies	____Hallucinations	Specific Fears: ________________________________	

Has your child ever been in counseling before? If so, when? Was it helpful? ________________________

____

What would your child/adolescent or yourself like as a result of counseling? _______________________

____

Name:____

Health History

Who is the child/adolescent's primary doctor?____

Overall health condition of child/adolescent: Very good Good Average Poor

Recent weight gain or loss? ____

Last physical exam: ________________________________ Report: ____

Significant medical conditions: ____

List any childhood diseases: ____

Any prolonged fever of more than 103 degrees? ____

Any head injuries? ____

Any hospitalizations? ____

Current medications: ____

Past medications including any adverse effects: ____

____

Was pregnancy planned or unplanned? ____

During the pregnancy was there drug or alcohol use? ________________ Type: ________________________

What were the emotional/financial/relational/situational stressors in your family during the pregnancy and early childhood of the client: ____

____

Any unusual situations or complications surrounding pregnancy, birth, and delivery? _________________________

____

School History

Name of school child is attending: __________________________________ Grade: ______________ GPA: _________

Has your child's behavior ever been a concern to his/her teachers? If so, please describe: _____________________

____

Does your child have any difficulties learning? ____

Does or did your child have any difficulties at school with any of the following: (please circle)

Writing **Reading** **Math** **Poor coordination** **Memories of letters or numbers**
Making friends **Bullying** **Being bullied** **Keeping friends** **Concentration**

What are your child's strengths in school? ____

____

Name:____

Legal History

Are there custody disputes or current custody arrangements in place for the child? __________________________

____

Are there any restraining orders in place which affect the child? ______________________________________

____

Are any family members currently on probation or parole, or currently incarcerated? ________________________

____

Family History

Describe for each parent the quality of home life (i.e. happy, tense, communication, relations with children, stability, security, religious commitment, abuse, etc.)____

____

____

____

Does the family or child have any religious affiliation? ____

If so, what role does this play in the family's life and the child's life? ______________________________________

____

What is the cultural background of the child? ____

What types of discipline are used within the family? ____

____

Describe the relationship between the child's parents: ____

____

Describe how the child gets along with others within the family: ______________________________________

____

Did either parent have similar characteristics or problems? ____

____

Is there a history of mental illness, or emotional problems within the family or extended family? _______________

____

Please list anyone in the child's family, including child and extended family that used/uses alcohol or drugs:

Relationship to child	Types of drugs	Purpose	For how long

Name:______________________________________

Personality of child: (please circle all that apply)

Tense	Relaxed	Restless	Calm	Daydreamer	Self-starter
Active	Sluggish	Stubborn	Loving	Aloof	Angry
Happy	Sad	Friendly	Secure	Easily frightened	Bold
Cautious	Whiny	Generous	Jealous	Cruel	Aggressive
Affectionate	Disobedient	Easy to manage		Eager to please	Relates easily to adults

Relates poorly to adults   Attached to certain toys/objects to the point of not being able to leave it at home

Have there been any noticeable changes in behavior or personality at any time in his/her life? ________________
____

How many moves has the family made and what was the age of the child at each move? _____________________
____

Child's mood in general:	Very happy	Happy	Average	Unhappy	Very unhappy
Child's mood in past 6 months:	Very happy	Happy	Average	Unhappy	Very unhappy

What is your child's greatest hope? ____
____

Please describe in detail the reason for having this child seen professionally.
Indicate the age the problem began and probable causes. What has made the problem better or worse? Describe feelings and moods observed. In what way does this problem interfere with the life of the child or family? ____
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