ADOLESCENT INTAKE FORM

Today's Date:_____

Adolescent's Name: (First) (M.I) (Last)	Birthdate: Age:	Gender: F M Other
Parent's Work Phone: Home/Cell Phone:	Parent's Work Phone: Home/Cell Phone:	
Parent's Name:	Age: Occupation:	Education Level:
Parent's Name:	Age: Occupation:	Education Level:
Legal Guardian:	Adolescent Currently Lives With:	
Step-Parent(s) (if applicable)		

Name of person completing form:_____

Please give a brief description of why you are seeking treatment:_____

_____

Who referred you to our clinic? _____

1. **FAMILY AND SOCIAL HISTORY**

Adolescent's Siblings:	Age	Sex	Grade	Adolescent's Siblings:	Age	Sex	Grade
_____	____	____	____	_____	____	____	____
_____	____	____	____	_____	____	____	____

Is the teen or any siblings adopted? _____

List all members living in the household:_____

If applicable give date(s) of adolescent's parents' marriage, separation(s), and/or divorce: _____

_____

Describe any family history of mental health or chemical dependency problems or treatment: _____

_____

Has any other member of the family ever been seen for services through BHSI? Yes No

If so, when?_____ Which family members were seen? _____

List any involvement with social services, child protection, the court system or legal services: _____

Has there been any physical, emotional, or sexual abuse? Yes No

2. SCHOOL HISTORY

Name of current school: _____ Grade _____

Schools attended: Elementary _____ Junior/Middle _____

List any special services received in schools and the grade level in which they were received: _____

_____

Do you have a job outside of school? Yes No

3. DEVELOPMENTAL HISTORY

Were there any problems in pregnancy, labor, birth or delivery with this adolescent? Yes No. If yes, please give details:

_____

_____

Have there been any concern or delays with your development in any of the following areas? If yes, please indicate who evaluated the problem if help was sought.

			Evaluated By:
1. Speech & language	Yes	No	_____
2. Hearing	Yes	No	_____
3. Vision	Yes	No	_____
4. Intelligence/ability to learn	Yes	No	_____
5. Bladder/Bowel Control	Yes	No	_____
6. Emotional/Maturity Level	Yes	No	_____
7. Social Skills	Yes	No	_____
8. Eating Habits	Yes	No	_____
9. Fine Motor Skills (writing, coloring, etc.)	Yes	No	_____
10. Gross Motor Skills (walking, running, etc.)	Yes	No	_____

4. MEDICAL HISTORY

Primary Care Clinic: _____ Physician: _____

Date of last medical examination: _____

List any current medical problems: _____

List any hospitalizations or serious medical problems: _____

List any medication currently taking: _____

List any medications previously prescribed/taken: _____

List any drug allergies: _____

Have there been any pregnancies, miscarriages, abortions? _____

Do we have your permission to contact your primary care physician to assist with coordination of your care? Yes No

5. CHEMICAL USE HISTORY

Please check any that apply:

Drug Name	Use currently	Within last 12 months	Have used in past	Never
Cannabis - Marijuana, Hash				
Alcohol				
Amphetamines - Speed, Cocaine, Crack, Crank, Dexedrine, White Crosses, Ritalin, Cylert, etc.				
Tranquilizers - Valium, Xanax, Ativan, Librium, Sleeping Pills, Seconal, Quaaludes, etc.				
Narcotics - Codeine, Percodan, Darvon, Demerol, Morphine, Heroin, Methadone, Talwin, etc.				
Other - Inhalants, PCP, LSD, Mushrooms, Paint Thinner, Glue, Nitrite "Poppers", etc.				

Have you used more than one chemical at the same time in order to get high? Yes No

Do you avoid family activities so you can use? Yes No

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

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

Do you use tobacco products? Yes No If yes, type _____ Quantity per day _____

Do you use caffeine? Yes No If yes, type _____ Quantity per day _____

6. PREVIOUS TREATMENT

List any counselors seen in the past and reason for visits: _____

_____

List dates of any psychiatric hospitalizations: _____

ADOLESCENT PROBLEM CHECKLIST

Please check if you have been experiencing any of the following symptoms/behaviors currently or over the past month.

- ☐ 1. sadness
- ☐ 2. crying easily
- ☐ 3. loss of interest or pleasure in activities
- ☐ 4. concerns about eating
- ☐ 5. weight loss or gain (circle)
- ☐ 6. decrease or increase in appetite (circle)
- ☐ 7. uncontrolled eating/dieting
- ☐ 8. excessive use of laxatives
- ☐ 9. tired a lot
- ☐ 10. don't like myself much
- ☐ 11. caring less about personal appearance
- ☐ 12. difficulty concentrating
- ☐ 13. want to hurt myself
- ☐ 14. thoughts of harming others
- ☐ 15. thoughts of death
- ☐ 16. panic attacks
- ☐ 17. nervousness
- ☐ 18. a lot of aches or pains
- ☐ 19. sexual concerns
- ☐ 20. problems at school
- ☐ 21. not doing homework
- ☐ 22. skipping school/classes
- ☐ 23. big changes in friends
- ☐ 24. blowing up about little things
- ☐ 25. getting into physical fights
- ☐ 26. not following rules at home or school
- ☐ 27. bothered by adults or teachers
- ☐ 28. problems with friends
- ☐ 29. trouble falling or staying asleep
- ☐ 30. irritable, angry feelings, crabby
- ☐ 31. fears, worries or anxieties
- ☐ 32. excessive energy
- ☐ 33. lying, stealing, destruction of property (circle)
- ☐ 34. more arguments with others
- ☐ 35. fighting with brothers or sisters
- ☐ 36. family problems
- ☐ 37. nightmares
- ☐ 38. relationship problems
- ☐ 39. problems with parents
- ☐ 40. engage in physically dangerous activities
- ☐ 41. impulsive/excitable
- ☐ 42. inattentive, easily distracted
- ☐ 43. restless, fidget excessively
- ☐ 44. unusual habits or compulsive behaviors