



MENTAL • EMOTIONAL • SPIRITUAL HEALTHCARE
1340 E Route 66 Suite 108 Glendora, CA 91740 626.863.3393

Please note that the information is important for your child’s care. Please fill out forms as completely as possible.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent’s Name: _____ Date of Birth: _____

Mother’s/Guardian’s Name: _____ Phone: _____

Mother’s/Guardian’s Physical Address: _____

Mother’s/Guardian’s Mailing Address: _____

Father’s/Guardian’s Name: _____ Phone: _____

Father’s/Guardian’s Physical Address: _____

Father’s/Guardian’s Mailing Address: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name Relationship (parent, sibling, etc.) Age Sex Type (bio, step, etc) Living with you? Y/N (If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent - Briefly describe the problem for which your adolescent is seeking to have counseling for?

What would you like to see happen as a result of counseling?

What is most concerning right now?

COUNSELING HISTORY Have your son or daughter previously seen a counselor?
Yes or No If Yes, where:

4 Approximate Dates of Counseling:

For what reason did your son or daughter go to counseling?

Does your son or daughter have a previous mental health diagnosis?

What was the Doctors name and number that gave the diagnosis?

What did you find most helpful in therapy?

What did you find least helpful in therapy?

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?

If yes, was it helpful? N/A____ Yes____ No____

Has your son or daughter taken medication for a mental health concern?
Yes____ No ____

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N ____ If so, please describe:

CHILD'S DEVELOPMENT Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:

Did your child experience any traumatic events (car accidents, domestic violence, surprising and upsetting events)? If so what age and what happened?

Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?

Yes ___ No ___ Not sure _____ If yes, describe:

Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___ Not sure _____ If yes, describe: _____

Has your child experienced emotional, physical, or sexual abuse? Yes ___ No ___ Not sure _____ If yes, describe:

CHEMICAL USE Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____ If yes, please explain your concern:

INTERNET/ELECTRONIC COMMUNICATIONS USAGE Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____ If yes, please explain your concern:

LEGAL ISSUES Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.

FAMILY HISTORY (Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Father's Name: _____ Birth Date: _____ Age: _____
Ethnic Origin: _____ Total years of education completed: _____
Occupation: _____ Place of Employment: _____
Military experience? Y/N _____ Combat experience? Y/N _____
Assessment of current relationship if applicable: Poor _____ Fair _____ Good _____

Mother's Name: _____ Birth Date: _____ Age: _____ Ethnic Origin: _____
Total years of education completed: _____ Occupation: _____
Place of Employment: _____ Military experience? Y/N _____
Combat experience? Y/N _____ Assessment of current relationship
if applicable: Poor _____ Fair _____ Good _____

PARENT'S MARITAL STATUS Single or Married (legally)? _____ Divorced _____
Cohabiting _____ Divorce in process _____ Separated _____ Widowed _____ Other _____

Length of marriage/relationship: _____ If divorced, how old
was your child at time of divorce? _____ If divorced, How much time does your
child spend with each parent? Mother _____%, Father _____%

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

- | | |
|--|---|
| <input type="radio"/> Fighting Disagreeing about relatives | <input type="radio"/> Divorce/separation |
| <input type="radio"/> Feeling distant | <input type="radio"/> Financial problems |
| <input type="radio"/> Disagreeing about friends | <input type="radio"/> Issues regarding remarriage |
| <input type="radio"/> Loss of fun | <input type="radio"/> Death of a family member |
| <input type="radio"/> Alcohol or Drug use | <input type="radio"/> Birth of a child |
| <input type="radio"/> Lack of honesty | <input type="radio"/> Inadequate health insurance |
| <input type="radio"/> Trauma Medical Concerns | <input type="radio"/> Job change or job dissatisfaction |
| <input type="radio"/> Infidelity (couple) Education problems | <input type="radio"/> Inadequate housing/feeling unsafe |

Other _____

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

What personal qualities would you say your son or daughter has?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

Is there anything else you would like me to know:
