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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: _____ Phone Contact: _____

Mother's/Guardian's Name: _____

Mother's/Guardian's Physical Address: _____

Mother's/Guardian's Mailing Address: _____

Father's/Guardian's Name: _____

Phone Contact: _____

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:

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 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 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?

Yes _____ No _____

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? Yes _____ No _____

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? Yes _____ No _____ Combat experience? Yes _____ No _____

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? Yes _____ No _____ Combat experience? Yes _____ No _____

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.

- Fighting Disagreeing about relatives
- Feeling distant
- Disagreeing about friends
- Loss of fun
- Alcohol or Drug use
- Lack of honesty
- Trauma Medical Concerns
- Infidelity (couple) Education problems
- Divorce/separation
- Financial problems
- Issues regarding remarriage
- Death of a family member
- Birth of a child
- Inadequate health insurance
- Job change or job dissatisfaction
- 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:
