

ADOLESCENT INTAKE EVALUATION

Teen's Name: _____ Date: _____

DOB: ___ Age: ___ Grade: School: _____

Pronouns: ___ Phone: _____

Parent/Guardian: ___ Relationship: _____

Parent Phone: ___ Email: _____

Emergency Contact: ___ Phone: ___

Insurance: ___ Referring Provider: _____

PRESENTING CONCERNS

Why are you here today? (Teen's perspective)

Parent's Concerns:

Current Problems (Check all that apply): Depression/sadness Anxiety/worry Anger/irritability Mood swings School problems Friend problems Family conflict Self-harm Suicidal thoughts Eating issues Sleep problems Substance use Risky behaviors Identity concerns Trauma symptoms ADHD symptoms Other: _____

When did problems start? _____

What was happening then? _____

SCHOOL AND ACADEMICS

Current School: _____

Grade: _ **GPA:** *Favorite Subject:* _____

Academic Performance: Excellent Good Average Below average Failing

Recent Changes in Grades: No Yes - Details: ___

School Attendance: Regular Some absences Frequent absences Truancy

School Relationships: Good friends Few friends No friends Bullied Bullying others

Teachers/Staff Relationships: Positive Neutral Negative Conflict

Special Services: None IEP 504 Plan Tutoring Counseling Other: _____

Future Plans: College Trade school Work Military Undecided

FAMILY RELATIONSHIPS

Lives with: Both parents Mom Dad Grandparents Other: _____

Parents' Relationship: Married Divorced Separated Never married Widowed

Siblings: None Number: _ **Ages:** _____

Family Relationships: Close Good Okay Strained Conflicted

Family Rules/Structure: Clear rules Some rules Few rules No rules Too strict

Communication with Parents: Open Good Okay Difficult None

Family Stressors: Financial problems Divorce/separation Illness Job loss Moving Death Substance use Mental illness Legal issues Other: _____

PEER RELATIONSHIPS

Friend Group: Large group Small group Few close friends One best friend No friends

Friend Relationships: Very close Close Casual Difficult Drama

Social Activities: Sports Clubs Arts Gaming Hanging out Parties Other: _____

Peer Pressure: None Some Significant pressure to: _____

Romantic Relationships: None Interested in someone Dating Serious relationship Relationship problems

IDENTITY AND DEVELOPMENT

Sexual Orientation: Straight Gay Lesbian Bisexual Pansexual Questioning Prefer not to say Other: _____

Gender Identity: Cisgender Transgender Non-binary Questioning Prefer not to say Other: _____

Support for Identity: Very supportive family Somewhat supportive Unsupportive Unknown

Body Image: Positive Neutral Negative Very negative

Self-Esteem: High Good Average Low Very low

TECHNOLOGY AND SOCIAL MEDIA

Daily Screen Time: <2 hours 2-4 hours 4-6 hours >6 hours

Social Media Use: Instagram TikTok Snapchat Discord YouTube Twitter Facebook Other: _____

Online Problems: None Cyberbullying Inappropriate content Online predators Gaming addiction Social media addiction Other: _____

Parental Monitoring: High Moderate Low None

RISK BEHAVIORS

Substance Use: None Alcohol Marijuana Vaping Prescription drugs
Other drugs: _____

Frequency: Never Tried once Occasional Regular Daily

Sexual Activity: None Some experience Sexually active Safe practices
Risky behaviors

Other Risk Behaviors: Reckless driving Fighting Stealing Running away
Self-harm Disordered eating Other: _____

MENTAL HEALTH SYMPTOMS

Mood Symptoms: Persistent sadness Hopelessness Mood swings Irritability
 Anger outbursts Emotional numbness Crying spells

Anxiety Symptoms: Excessive worry Panic attacks Social anxiety Phobias
Separation anxiety Performance anxiety

Attention/Hyperactivity: Difficulty concentrating Easily distracted Hyperactive
 Impulsive Disorganized Forgetful

Sleep Issues: Trouble falling asleep Frequent waking Nightmares Too much sleep
 Too little sleep

Eating Issues: Appetite changes Weight changes Body image concerns
Restrictive eating Binge eating Purgging

SAFETY ASSESSMENT

Self-Harm: None Thoughts Past behavior Current behavior Methods:

Suicidal Thoughts: None Passive Active Plan Previous attempts Details: _____

Risk to Others: None Thoughts Threats Past violence Details: _____

Protective Factors: Family support Friends Pets Future goals Hobbies Sports/activities Religious beliefs Other: _____

STRENGTHS AND INTERESTS

Personal Strengths: Smart Creative Funny Kind Athletic Musical Artistic Leader Good friend Resilient Other: _____

Hobbies/Interests: Sports Music Art Reading Gaming Cooking Animals Nature Technology Other: _____

Goals/Dreams:

What makes you happy?

TREATMENT GOALS

What would you like to change? 1. _____ 2. _____ 3. _____

How motivated are you for therapy? Very motivated Somewhat motivated Not sure Not motivated

Therapy Preferences: Individual only Family therapy Group therapy No preference

PARENT/GUARDIAN INPUT

Additional Concerns:

Family Goals:

Previous Treatment: None Individual therapy Family therapy Medication
School counseling Other: _____

CLINICAL IMPRESSIONS

Primary Concerns:

Recommended Treatment: Individual therapy Family therapy Group therapy
 Psychiatric evaluation School consultation Other: _____

Frequency: Weekly Bi-weekly Family sessions: _____

Teen Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

Confidential treatment record protected by HIPAA and state confidentiality laws.