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Intake Form - Adolescent

Full Name: _____		Today's Date: _____
Age: _____	Birth Date: _____	Male or Female (Circle One)
Address: _____		City/State: _____
Zip: _____	Grade: _____	School: _____
Emergency Contact Name _____		Emergency Contact Number: _____
Relationship to You: _____		From Completed By: _____
Handedness (Circle One)	Left Right Mixed	Relationship to Client: _____

Please check all applicable options and add comments as needed

I. Questions Regarding Overall Health:

Date of last physical: _____

Do you suffer from any of the following?

A. Sleep

- Difficulty Falling Asleep or Staying Asleep
- Difficulty Waking
- Restless Sleep
- Sleepwalking/Night terrors/Nightmares
- Bruxism (Grinding teeth)

B. Auditory/Olfactory

- Ringing in the Ears
- Hearing Loss
- Ear aches
- Decrease in Sense of Smell

C. Visual

- Double Vision
- Vision Problems/Blurred Vision
- Blind Spots

Clinician's Notes

Onset:

Duration:

Length:

Quality:

Dreams:

D. Other

- Allergies
- Asthma
- Frequent illness
- Fatigue
- Chronic pain

Clinician's Notes

E. Cardiovascular / Pulmonary

Heart Problems Breathing Problems Palpitations or Tachycardia Hypertension

Clinician's Notes

F. Dermatological

Skin Problems _____

G. Endocrine

Hot/ Cold Sensitivity Diabetes Sugar Sensitivity
 Excessive Thirst Appetite Awareness Thyroid Disorder
 PMS Incontinence

Clinician's Notes

H. Gastrointestinal

Stomach Pain Chronic Constipation Irritable Bowel Nausea or Vomiting

Clinician's Notes

I. Neurological

Headaches Fainting Tremor or Spasticity
 Coordination Speech Problems Accident Prone
 Weakness Balance Over-active
 Motor or Vocal Tics Seizures Under-active

Clinician's Notes

J. Attention and Organization

Attention Span Distractibility Impulsivity Organizational Ability

Clinician's Notes

K. Habits (Please indicate both past and present participation)

Caffeine Intake Alcohol Use Cigarette Use Recreational Drug Use

Dietary Habits (Please characterize your general eating habits)

L. Behavior/Emotions

Mood Swings Eating Disorders Tantrums/Violent Behavior
 Panic Attacks Depression Risk-Taking Behavior
 Manic-Depression Anger/Aggression Obsessive Compulsive
 Anxiety Addictions Symptoms
 Irritability Fears/Phobias

Clinician's Notes

M. School Behavior and Performance

Math Writing Problems with
 Spatial Skills Memory Homework
 Art Reading Teacher Complaints
 Verbal Expression

Favorite Subjects (Strengths) _____

Least Favorite Subjects (Weaknesses) _____

N. Home Behavior

Problems with Parents Problems with Siblings

Clinician's Notes

II. Personal History

A. Perinatal

Prenatal Stress or Injury
 Difficult Birth
 Adopted at age

Prenatal Drug Exposure
 Premature or Late Birth
 Difficult Labor

Medical Problems after Birth

B. Growth and Development

Colic
 Activity Level
 Motor Development
 Chronic Ear Infections

Sleep Problems
 Attachment
 Allergies
 Asthma

Eating Problems
 Emotional Development
 Language Development

C. Physical Traumas

Head Injury
 Serious Illness
 Poisoning

Accidents
 CNS Infection
 Anoxia

Extreme Fever
 Drug Overdose
 Stroke

D. Psychological Traumas and Stresses

Abuse or Neglect Family Stress School/Job Stress Death in Family Illness

E. Spiritual (Please be as specific as possible, estimating frequency of involvement)

Prayer Fasting Meditation Bible/Wisdom Literature Reading Other

Denominational Affiliation: _____

Clinician's Notes

Treatment History

Medications: (Use backside if more room is needed)

Medication	For Condition	Dose	Dates

Medical Treatment:

Procedure	For Condition	Physician Address/Phone	Dates

Psychological Therapy:

Therapy	For Condition	Therapist Address/Phone	Dates

Other Therapy:

Therapy	For Condition	Therapist Address/Phone	Dates

Family History

Symptom	Yes	No	Relationship to You
Asthma			
Autoimmune Disorders: Type 1 Diabetes, Rheumatoid Arthritis, Lupus, MS, Scelorderma, etc.			
Migraine			
Sleep Problems			
Depression			
Manic-Depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Eating Disorders or Obesity			
Addictions			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Learning Problems			
Conduct Problems or Criminal			
Behavior			
Autism Spectrum			
Schizophrenia			