**Thrive Family Co.**

1152 2nd Avenue

Ladysmith, BC, V9G 1A1

Phone: (250) 924-4226

**Adolescent Intake Form**

| **Demographics** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Legal Name: | | | | | Date of Intake: | | |
| Address: | | | | | | | |
| Email: | | | | Phone #: | | | |
| Leave Message Okay: | | * Yes | * No | Text Reminder Okay: | | * Yes | * No |
| Gender Assigned at Birth: | | | | * she/hers | * he/his | * they/them | |
| DOB: | | | Age: | Ethnicity: | | | |
| School: | | | Grade: | IEP Plan? | | * Yes | * No |
| Person Filling out Form: | | | | | | | |
| With whom do you live? | | | | Custody Concerns? | | * Yes | * No |
| Name of Parent/Legal Guardian: | | | | | | | |
| Address: | | | | | | | |
| Email: | | | | Phone #: | | | |
| Name of Parent/Legal Guardian: | | | | | | | |
| Address: | | | | | | | |
| Email: | | | | Phone #: | | | |
| Referral Source: | | | | | | | |

| **Assessment** | | | | | | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Previous Assessments: | | | | | | | | | | | | | | | | | | | | | |
| Previous Counseling: | | | * Yes | * No |  |  | | | | | | | | | | | | | | | |
| What did you find most helpful? | | | | | | | | | | | | | | | | | | | | | |
| What did you find least helpful? | | | | | | | | | | | | | | | | | | | | | |
| How long do you expect to be in counseling? | | | | | * 1-3   sessions | | * 4-10   sessions | | | | * Long   Time | | | | | * No Idea | | | |  | |
| Primary Area of Concern: | | | | | | | | | | | | | | | | | | | | | |
| When did these concerns start? | | | | | | | | | | | | | | | | | | | | | |

| How intense is your emotional distress? | | | | | | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mild | | | * 1 | * 2 | * 3 | * 4 | * 5 | * 6 | * 7 | * 8 | * 9 | * 10 | | Severe | | |
| How much does your primary concern affect your ability to perform at school, get along with others and perform daily tasks? | | | | | | | | | | | | | | | | |
| Mildly Disruptive | | | * 1 | * 2 | * 3 | * 4 | * 5 | * 6 | * 7 | * 8 | * 9 | * 10 | | Incapacitating | | |
| Goals for Counseling: | | | | | | | | | | | | | | | | |
| Personal Strengths: | | | | | | | | | | | | | | | | |

| **Medical History** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Primary Care Physician: | | | | | Phone #: | |
| Chronic Medical Concerns: | | * Yes | * No | If yes, please explain: | | |
| Head Trauma/Concussions? | | * Yes | * No | If yes, please explain: | | |
| Relevant Diagnosis: | | | | | | |
| Current Medications: | | | | | | |

| **Developmental History** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Complications prior to birth: | | * Yes | * No | Complications at birth: | | | * Yes | * No |
| All developmental milestones met? | | | * Yes | * No | If no, please explain: | | | |

| **Chemical Use History** | | | | | |
| --- | --- | --- | --- | --- | --- |
| **Chemical** | **Used in the Past**  **Y/N** | **Currently Using**  **Y/N** | **Frequency** | **Received Treatment**  **Y/N** | **Notes** |
| Alcohol |  |  |  |  |  |
| Tobacco |  |  |  |  |  |
| Marijuana |  |  |  |  |  |
| Other Drugs |  |  |  |  |  |
| **Chemical Use Questions:** | | | | **Y/N** | **Notes** |
| Ever use more than 1 chemical at a time? | | | |  |  |
| Do you avoid family activities so you can use? | | | |  |
| Do you have a group of friends who also use? | | | |  |
| Do you use to improve your emotions, such  as when you’re sad or depressed? | | | |  |

| Family & Personal History | | | | |
| --- | --- | --- | --- | --- |
| Names & Ages of Siblings | | | | |
| Name: | Age: | Name: | | Age: |
| Name: | Age: | Name: | | Age: |
| Name: | Age: | Name: | | Age: |
| Name: | Age: | Name: | | Age: |
| Who lives in your home with you? | | | | |
| Do you have visits with another parent? | * Yes | * No | If yes, how often do you visit? | |
| Do you have siblings that live in another home? | * Yes | * No |  | |
| Describe your relationship with family: | | | | |

| **Mental Health History** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| Issue/Diagnosis | | Self | Mother | Father | Sibling | Grandparent |
| Depression | |  |  |  |  |  |
| Anxiety | |  |  |  |  |  |
| Bipolar Disorder | |  |  |  |  |  |
| Schizophrenia | |  |  |  |  |  |
| Post Traumatic Stress | |  |  |  |  |  |
| Drug/Alcohol Addiction | |  |  |  |  |  |
| Eating Disorder | |  |  |  |  |  |
| Suicide | |  |  |  |  |  |
| Violence | |  |  |  |  |  |
| Problems with Focus or Attention | |  |  |  |  |  |
| Other: | |  |  |  |  |  |

| **Peer Relationships & School** | | | | | | **Yes** | **No** | **Further Info** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Any behavior or academic concerns? | | | | | |  |  |  |
| Are you happy with the amount of friends you have? | | | | | |  |  |  |
| Do you consider yourself an introvert or extrovert? | | | | | |  |  |  |
| Have you ever been bullied? | | | | | |  |  |  |
| Are you involved in any extracurricular activities? | | | | | |  |  |  |
| Do you like school? | | | | | |  |  |  |
| Do you attend regularly? | | | | | |  |  |  |
| What are your current grades? | | | | | |  |  |  |
| Do you feel you're doing your best in school? | | | | | |  |  |  |
| Are you dating? | | | | | |  |  |  |
| Are you currently in a relationship? | | | | | |  |  |  |
| Describe your relationship with friends: | | | | | | | | |
| What do you do for fun? | | | | | | | | |

| **Personal Concerns** | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Symptom** | **None** | **Mild** | **Mod** | **Severe** | **Symptom** | **None** | **Mild** | **Mod** | **Severe** |
| Sadness |  |  |  |  | Excessive worry |  |  |  |  |
| Crying |  |  |  |  | Low self worth |  |  |  |  |
| Sleep issues |  |  |  |  | Anger issues |  |  |  |  |
| Issues at home |  |  |  |  | Spiritual  concerns |  |  |  |  |
| Hyperactivity |  |  |  |  | Hallucinations |  |  |  |  |
| Binging/purging |  |  |  |  | Racing thoughts |  |  |  |  |
| Loneliness |  |  |  |  | Restlessness |  |  |  |  |
| Appetite changes |  |  |  |  | Drug use |  |  |  |  |
| Social isolation |  |  |  |  | Alcohol use |  |  |  |  |
| Bullying |  |  |  |  | Easily distracted |  |  |  |  |
| Paranoid  thoughts |  |  |  |  | Trauma/  flashbacks |  |  |  |  |
| Poor  concentration |  |  |  |  | Obsessive  thoughts |  |  |  |  |
| Indecisiveness |  |  |  |  | Panic attacks |  |  |  |  |
| Low energy |  |  |  |  | Feeling anxious |  |  |  |  |
| Unresolved guilt |  |  |  |  | Feeling panicky |  |  |  |  |
| Irritability |  |  |  |  | Suicidal thought |  |  |  |  |
| Nausea |  |  |  |  | Past suicide  attempts |  |  |  |  |
| Social anxiety |  |  |  |  | Impulsivity |  |  |  |  |
| Self mutilation |  |  |  |  | Nightmares |  |  |  |  |
| Cutting |  |  |  |  | Hopelessness |  |  |  |  |
| Elevated Mood |  |  |  |  | Disorganized |  |  |  |  |
| Mood Swings |  |  |  |  | Grief |  |  |  |  |
| Anorexia |  |  |  |  | Phobias |  |  |  |  |
| Headaches |  |  |  |  | Other |  |  |  |  |

| Is there anything further you’d like us to know? |
| --- |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Printed Name Signature Date

**\*If child is under States legal age for mental health treatment add guardian signature below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent/guardian: Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of parent/guardian: Signature Date