**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