CHILD AND ADOLESCENT INTAKE FORM

Adolescents please fill out pages 1-3. Parent/guardian please fill out pages 4-8.

Welcome to Deep Dive Individual & Family Counseling Services! Get ready to take a dive into your life by answering this intake form questionnaire. Please note that open and honest answers to the questions below are important for providing you with the most useful treatment and care. Please fill out this form to the best of your ability and provide it to your therapist once completed.

ADOLESCENT SECTION
TO BE COMPLETED BY CLIENTS AGES 13 TO 17
For youth ages 12 or younger, this section can be completed by the parent or guardian

CLIENT INFORMATION

Name: ____
Date of Birth: ____ Age: ____________

Gender: ____________________________________ Race/Ethnicity: _________________________

Phone (Cell): _______________________________Messages okay?______ Text reminders okay?________
School: ____ Grade: ______________
Do you use electronic communications such as Facebook, Twitter, Snap Chat, Instagram, etc.?
____

Do your parents have access to your electronic communication? YES or NO_____________________________

Do your parents have any problems with your use of cell phone, text, or social media communications?
YES or NO__________

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? ____________________________
____

Have you participated in any sports, clubs, music, volunteering or other activities either in the past or currently?

____

Who are the most influential and supportive people in your life? __________________________________

Who are the least supportive people in your life? ____

Do you have a religion or system of beliefs? If so, please describe. ___________________________________
____
____

CURRENT REASON FOR SEEKING COUNSELING

Please describe the reason you are seeking counseling services at this time. ______________________________
____

What are you hoping will change or improve as a result of counseling? ___________________________________
____

COUNSELING/MEDICAL HISTORY

Have you seen a counselor in the past? YES or NO

If yes, what did you find most helpful in therapy? ____

If yes, was there anything about the therapist that was not helpful? ______________________________________

SUBSTANCE USE- PAST AND PRESENT

Do you currently use alcohol? YES or NO

If yes, how often do you drink? Daily ______ Weekly ______ Occasionally _______ Rarely _______

If yes, how many drinks do you usually drink in one sitting? ____________

Do you currently use tobacco? YES or NO

If yes, how much do you smoke/chew? ________________________

Do you currently use any other drugs including vaping? Yes ______ No ______

If yes, what drugs do you use? ____

If yes, how often do you use? Daily ______ Weekly ______ Occasionally _______ Rarely _______

Have you received any previous treatment for drug or alcohol use? YES or NO

If yes, where did you go? ____
____Inpatient Treatment _________Outpatient Treatment

Adolescents, please answer the following with Yes or No.

1. Have you ever used more than one (1) drug or substance at the same time to get high? _________

2. Do you avoid family activities, so you can use? ____

3. Do you have a group of friends who also use? ____

4. Do you use to improve your emotions such as when you feel lonely, worried or sad? _______________

LEGAL ISSUES

Please list any legal issues that are currently affecting you or your family or that have had a significant effect upon you in the past. ____

FAMILY HISTORY

1. Are your parents married or divorced? ____
2. Do you think their relationship is good? ____
3. If your parents are divorced, whom do you primarily live with? _____________
4. How often do you see each parent? Mom_________% Dad ___________%.
5. Do you have any sisters or brothers? ____
6. Do you have any pets? ____
7. What does your family do together for fun? ____
8. What do you like most about your family? ____
9. What do you like least about your family? ____

FAMILY DYNAMICS

Is your family experiencing any of these things? If yes, please check the box beside the item.

Adoption		Loss of Fun	
Alcohol Use		Marriage Problems	
Arguing		Money Problems	
Birth of a Child		No Health Insurance	
Death of a Family Member		Physical Abuse	
Death of a Friend		Physical Fighting	
Disagreeing about Family		Recent Move/Planning to Move	
Disagreeing about Friends		Remarriage	
Drug Use		School Problems	
Emotional Abuse		Sexual Abuse	
Feeling Unsafe		Want more family time	
Health Problems		Other:	
Housing Problems		Other:	
Lack of Honesty		Other:	

PEER RELATIONS

1. How do you consider yourself socially: outgoing ____ shy ____ depends on the situation ______

2. Are you happy with the number of friends you have? YES or NO

3. Have you ever been bullied? YES or NO 4. Are your parents happy with your friends? YES or NO

5. Have you ever experienced bullying either in person or on social media? YES or NO

SCHOOL HISTORY

1. Do you like school? YES or NO 2. Do you attend regularly? YES or No

3. What are your current grades? ______ 4. Do you feel you are doing the best you can at School? YES or NO

*I would like you to know that I have worked with many adolescents and I respect your privacy. I hope to create an atmosphere where you feel comfortable sharing and learning.

ADOLESCENT INTAKE FORM (PARENT/GUARDIAN SECTION)

Welcome to Deep Dive Individual & Family Counseling Services! Please note open and honest answers to the questions below are important for your child's treatment and care. Please fill out this form to the best of your ability and provide it to your therapist once completed.

PARENT/GUARDIAN INFORMATION

Name: ____

Date of Birth: ____ Age: ______________

Gender: ____ Race/Ethnicity: _____________________________

Phone (Cell): _____________________________________Messages okay?_______ Text reminders okay?________

Religious Preference: ____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Family Member	Name	Age	Lives with Patient?	List any mental health concerns
Father				
Mother				
Sibling				
Sibling				
Sibling				
Other				
Other				
Other				

CURRENT REASON FOR SEEKING COUNSELING

Please describe the reason you are seeking counseling services at this time. _______________________________

____

What are you hoping will change or improve as a result of counseling? ____________________________________

____

What is most concerning to you right now regarding your child? ____

____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:

____

2. Did your child have health problems at birth? Yes _____ No ______ If yes, describe:

____

3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes ___ No ___ Not sure_____ If yes, describe: ____

4. Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___ Not sure_____

If yes, describe: ____

5. Has your child experienced emotional, physical, or sexual abuse? Yes ____ No ____ Not sure _____

If yes, describe: ____

COUNSELING HISTORY

Has 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 _________

Name of medication(s) and approximate dates taken: ____
____

Do you feel the medication was/is helpful? YES or NO

Does your son or daughter have other medical concerns or previous hospitalizations? YES or NO

If so, please describe. ____

SUBSTANCE USE

Do you have any concerns with your son or daughter using alcohol or drugs? YES or 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 social media communications such as Facebook, Snap Chat, Twitter, texting etc? YES or NO

If yes, please explain your concern: ____

LEGAL ISSUES

Please list any legal issues (i.e. adoption, bankruptcy, incarceration, marriage, divorce, etc.) that are affecting you or your child or have had a significant effect upon you or your child in the past. ________________________
____

FAMILY HISTORY

Are you aware of any trauma you experienced from ages 0-3?
____
____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside of your home? Please describe as much as you feel comfortable. ____
____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? __________________
____

PARENT'S MARITAL STATUS (These questions refers to the biological parents' relationship)

Single ______ Married (legally) ______ Divorced ______ Cohabitating _______ 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 _____%

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 a parent who is not present or available.

Biological Father's Name: _______________________________________Birth Date:_________ Age: _____
Ethnic Origin: _______________________ Education: ______________ Occupation: _______________________
Place of Employment: ____

Military experience? Y/N ____________ Combat experience? Y/N _________________

Current Marital Status _____Single ____Married ____Divorced ____Separated _____Widowed _____Other

*Please answer if you are no longer with your child's biological mother OR check here if you are still with the child's biological mother___________

General assessment of the current relationship if applicable: Poor_____ Fair_______ Good_________

Biological Mother's Name: ______________________________________Birth Date:_________ Age: _____
Ethnic Origin: ________________________Education: ______________ Occupation:___________________
Place of Employment: ____

Military experience? Y/N _____________ Combat experience? Y/N __________________
Current Marital Status _____Single ____Married ____Divorced ____Separated _____Widowed _____Other

*Please answer if you are no longer with your child's biological father OR check here if you are still with the child's biological father___________

General assessment of current relationship if applicable: Poor_____ Fair_______ Good_________

FAMILY DYNAMICS

Is your family experiencing any of these things? If yes, please check the box beside the item.

Adoption		Loss of Fun	
Alcohol Use		Marriage Problems	
Arguing		Money Problems	
Birth of a Child		No Health Insurance	
Death of a Family Member		Physical Abuse	
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Drug Use		School Problems	
Emotional Abuse		Sexual Abuse	
Feeling Unsafe		Want more family time	
Health Problems		Other:	
Housing Problems		Other:	
Lack of Honesty		Other:	

YOUR CHILD'S STRENGTHS

What activities do you feel your son or daughter is successful when he or she tries?

____

____________________________ ____

What positive personal qualities would you say your son or daughter has?

____

____

Who would or what would you say is most influential in your child's life? _________________________________

____

____

Is there anything else you would like to share:

____

____

____

*Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the therapist. This means that some of the issues that are discussed will stay between the child and the therapist, and that the therapist will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. I also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why I will always encourage your child to be truthful with you. I will encourage, prepare and support your child in feeling safe enough to share difficult matters with you. You should know that this confidentiality has limits. If there is any threat to your child's life, I have the duty to inform you and help to create a plan for safety. In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include threats of harm against another person, physical, emotional or sexual abuse, neglect, and pregnant women who report using drugs. Finally, we recognize how challenging it can be for a parent to raise a child, especially if the child is struggling with mental health concerns. I know how badly you might want to know everything your child may have kept a secret from you. I want to be your partner in supporting your child's psychological and emotional wellbeing. Please know that even when I cannot discuss certain details about your child with you, I will always be there to guide you and give your child the best advice possible to protect him or her and encourage healthy decisions, including being open and honest with you.

Respectfully,

Shenna Fisher, LCSW

Parent/Guardian: If you consent to your child or adolescent receiving therapy treatment at Deep Dive Individual & Counseling Services, PLLC, please print and sign your name below:

Parent/Guardian Name: ____

Parent/Guardian Signature: ____

Today's Date: ____