Welcome to Oak Creek Relational Counseling Center. Please note that this information is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM **(ages 12-17)**

Adolescent, please fill out pages 1-3, parent/guardian please fill out pages 4-8

CLIENT INFORMATION

Name: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female ❒ Non-binary ❒ Other

Phone (Cell): _____ Messages okay? _____ Text reminder: okay? _____

School: _____ Grade: _____

Please Share electronic communication (Facebook, Twitter, Snapchat, Instagram, etc) that you use:

_____

Do your parents have access to your electronic communication? (Y/N) _____

Do they have any issues with your use of phone, text, electronic communication? (Y/N) _____

PERSONAL STRENGTHS

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

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____

_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling for? _____

_____

What would you like to see happen as a result of counseling? _____

_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒ Yes ❒ No

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

_____

If yes, what did you find **least helpful** in therapy? _____

_____

CHEMICAL USE AND HISTORY

Do you currently use alcohol? _____Yes,_____ No
If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely
If yes, how much do you drink? _____ (#) per time.
Do you currently use Tobacco? _____Yes, _____No
If yes, how much do you smoke/chew? _____
Do you currently use any other drugs? _____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 chemical use? Y/N _____
If so, where did you go?_____
Inpatient_____Outpatient _____
Please answer the following with Y/N

1. Have you ever used more than 1 chemical 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 sad or depressed?? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present or 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? (Y/N/Unsure)_____
3. If your parents are divorced, whom do you primarily live with? _____
4. How often do you see each parent? Parent 1:_____ ____% Parent 2:_____ ____%
5. Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

   _____

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing*)

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially:____outgoing_____shy_____depends on the situation
2. Are you happy with the amount of friends you have? (Y/N)_____
3. Have you ever been bullied? (Y/N) _____
4. Are your parents happy with your friends? (Y/N)_____
5. Are involved in any organized social activities (e.g. sports, scouts, music)? _____

SCHOOL HISTORY

1. Do you like school? (Y/N)_____
2. Do you attend regularly? (Y/N)_____
3. What are your current grades? _____
4. Do you feel you are doing the best you can at School? (Y/N) _____

INDIVIDUAL CONCERNS

SYMPTOM	NONE	MILD	MOD	SEVERE		SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS						APPETITE CHANGES				
CRYING						SOCIAL ISOLATION				
SLEEP DISTRUBANCES						PARANOID THOUGHTS				
PROBLEMS AT HOME						POOR CONCENTRATION				
HYPERACTIVITY						INDECISIVENESS				
BINGING/PURGING						LOW ENERGY				
LONELINESS						EXCESSIVE WORRY				
UNRESOLVED GUILT						LOW SELF WORTH				
IRRITABILITY						ANGER ISSUES				
NAUSEA/INDIGESTION						SPIRITUAL CONCERNS				
SOCIAL ANXIETY						HALLUCINATIONS				
SELF MUTALATION						RACING THOUGHTS				
CUTTING						RESTLESSNESS				
IMPULSIVITY						DRUG USE				
NIGHTMARES						ALCOHOL USE				
HOPELESSNESS						EASILY DISTRACTED				
ELEVATED MOOD						TRAUMA FLASHBACKS				
MOOD SWINGS						OBSESSIVE THOUGHTS				
DISORGANIZED						PANIC ATTACKS				
ANOREXIA						FEELING ANXIOUS				
GRIEF						FEELING PANICKY				
PHOBIAS						SUICIDAL THOUGHTS				
HEADACHES						PAST SUICIDE ATTEMPTS				
WEIGHT CHANGES (UNPLANNED CHANGES)						OTHER				

*We would like you to know that we have worked with a lot of adolescents and that we respect your privacy, and we hope to create an atmosphere where you feel comfortable sharing.

Welcome to Oak Creek Relational Counseling Center. Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____

Date of Birth: _____ Age: _____ ❒Male ❒Female ❒Non-binary ❒Other

Race/Ethnic Origin: _____

Religious Preference: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for? _____

_____

_____

What would you like to see happen as a result of counseling? _____

_____

What is most concerning right now? _____

_____

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 child previously seen a counselor? ❒Yes ❒No

If yes, where: _____

Approximate dates of counseling: _____

For what reason did your child go to counseling? _____

Does your child have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy? _____

_____

What did you find **least helpful** in therapy? _____

_____

Has your child 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	Dates taken	Was it helpful? (Y/N)

Does your child have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe. _____

CHEMICAL USE

Do you have any concerns with your child using alcohol or drugs? (Y/N) _____

If yes, please explain your concern: _____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your child using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern: _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, at present, or have had a significant effect upon you or your child in the past. _____

_____

FAMILY HISTORY

Are you aware of any birth trauma your child experienced from age 0-3? _____

_____

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

_____

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

_____

❒ 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? Parent 1_____%, Parent 2_____%

(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 the other parent.)

Parent 1's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed:_____Occupation:_____

Place of Employment: _____

Military experience? Y/N_____ Combat experience? Y/N _____

Current Status_____Single,_Married,_Divorced,_Separated,_____Widowed,_____Other
Assessment of current relationship if applicable: Poor____Fair_____Good_____

Parent 2's Name:_____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed:_____Occupation:_____

Place of Employment: _____

Military experience? Y/N_____ Combat experience? Y/N _____

Current Status_____Single,_____Married,_____Divorced,_____Separated,_____Widowed,_____Other

Assessment of current relationship if applicable: Poor_____Fair_____Good_____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your child is successful when they try? _____

_____

What personal qualities would you say your child has? _____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your child's life? (Please describe) _____

_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR CHILD

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGES				
SLEEP DISTRUBANCES					PARANOID THOUGHTS				
DISSOCIATION					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/PURGING					LOW ENERGY				
DECREASED SEX DRIVE					EXCESSIVE WORRRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF MUTALATION					RACING THOUGHTS				
CUTTING					RESTLESSNESS				
IMPULSIVITY					DRUG USE				
NIGHTMARES					ALCOHOL USE				
HOPELESSNESS					DECREASED CREATIVITY				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					WORK ISSUES				
ANOREXIA					PROBLEMS AT HOME				
SOCIAL ISOLATION					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
OBSESSIVE THOUGHTS					FEELING PANICKY				
GRIEF					SUICIDAL THOUGHTS				
HEADACHES					PAST SUICIDE ATTEMPTS				
LONELINESS					OTHER				

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, and/or treatment team providing their care. This means that some of the issues that they discuss will stay between them, and that we 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. We 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 we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to California law, and the federal patient privacy law known as HIPAA, your child will need to give their consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.

- You should know that this confidentiality has limits. If there is any threat to your child's life, we 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 against another person, physical 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 when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect them and encourage healthy decisions, including being open and honest with you.