Lacamas Counseling & Psychiatry
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LACAMAS COUNSELING & PSYCHIATRY

INTAKE INFORMATION - ADOLESCENT

CONTACT INFORMATION & DEMOGRAPHICS

Full name: _____ **Date:**_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email address: _____ **Phone:** _____

Check mark approved communication: □Voicemail □Text □Email

Parent/Legal Guardian: _____

Email address: _____ **Phone:** _____

Check mark approved communication: □Voicemail □Text □Email

Parent/Legal Guardian: _____

Email address: _____ **Phone:** _____

Check mark approved communication: □Voicemail □Text □Email

Is there a parenting plan (if so, please provide a copy)? □YES □NO

Emergency Contact Name & Phone: _____

DOB: _____ **Age**: _____ **Sex:** □**Male** □**Female** □_____

Gender Identity: _____ **Preferred Pronouns:** _____

Race/Ethnicity: _____

Occupation: _____

Spiritual/Religious Beliefs: _____

Referred by: _____

What concerns or problems bring you to counseling?

_____

_____

_____

What are your goals for counseling?

_____

_____

What do you like to do for fun or enjoyment? Do you have any hobbies that you enjoy regularly? Do you prefer your enjoyment alone, with others, or both?

_____

_____

Describe any pertinent (relevant) family history, abuse, or trauma

_____

_____

Please describe any family history of mental illness or diagnoses

_____

_____

Describe any past or current suicidal thoughts or attempts

_____

_____

Describe any addictions or addictive behaviors that affect you

_____

_____

Have you ever experienced any bullying or hazing?

_____

_____

SCHOOL INFORMATION

School Name _____

What is your typical school schedule?

_____

_____

What was your grade point average last report card? Is that normal, worse, or better for you?

_____

_____

What is school like for you?

_____

_____

Have you ever attended any special classes (i.e., resource program, gifted programs) or had any formalized school accommodations or Individualized Education Plans?

_____

_____

During the past school year, about how many days were you absent when you were supposed to be in school?

_____

_____

Have you ever been suspended or expelled from school? If yes, please share additional details.

_____

_____

MEDICAL PROVIDERS

Primary Care Physician Name _____
Phone Number _____
Clinic Name _____
Date of last Appointment _____

List any pertinent mental health diagnosis, medical conditions, health problems, and/or past hospitalizations

_____

_____

List any medications you are taking and for what reason

_____

_____

PREVIOUS MENTAL HEALTH PROVIDERS

Name/Clinic Name _____
Phone Number _____
Date of last Appointment _____

How was your experience and what was your diagnosis?

_____

_____

OTHER PROVIDERS

Name/Clinic Name _____
Phone Number _____
Date of last Appointment _____

Please describe the goals and outcomes with this provider

_____

_____

FAMILY

Who lives with you:

Name	**Age**	**Relationship**

Please describe your relationship with your mother.

Please describe your relationship with your father.

Please describe your relationship with your siblings.

If you are in a romantic or sexual relationship, please describe the nature of the relationship and months/years together.

Describe your sexual activity

Who do you know that you would consider your closest sources of support or your "inner circle" (e.g., grandparent, aunt, uncle, friend, cousin, teacher, etc.)?

Who else is significant and/or supportive in your life?

What is your work or volunteer history?

What else would you like me to know:

Check any of the following symptoms that have impacted your child in the last six months

Depressed Mood
Tiredness/Fatigue
Low energy
Tearfulness
Hopelessness
Apathy/Lack of care
Loss of interest/pleasure
Low self-worth
Low motivation
Isolation from others
Difficulty concentrating
Racing thoughts
Lack of confidence
Increased appetite
Decreased appetite
Irregular sleeping
Anxiety
Panic
Fear
Social anxiety
Panic attacks
Thoughts of harming others
Suicidal thoughts
Self-harm
Guilt/Shame
Inconsistent mood changes
Excessive Energy
Impulsivity
Compulsive Behaviors
Obsessions
Hear/see things others do not
Paranoia/Suspicion
Reckless Behaviors
Exposure to traumatic event
Flashbacks (while awake)
Nightmares
Avoid trauma reminders
Easy startle reflex
Irritability/Anger
Frequent anger outbursts
Other symptoms _____

What stressors/changes have recently impacted you?

Parents
Siblings
Extended Family
Friends & Social Life
School
Sports
Work
Alcohol/Drugs
Legal Matters
Food/Diet
Body Image
Recent Move
Medical/Health
Grief/Loss/Death
Finances
Bullying
Sexual abuse/rape
Physical abuse
Gender Identity & Sexuality
Pregnancy/Abortion
Chaotic Life
Other _____

How are these symptoms and stressors affecting your every day life?

Personally _____
Family _____
Friendships _____
Social life _____
Work/School _____
Every day tasks _____