

DISCOVERY COUNSELING ASSOCIATES TEEN INTAKE FORM

INSTRUCTIONS: PLEASE COMPLETELY FILL OUT BOTH SIDES.

Date: _____ Form filled out by: Self Other: _____
Client Name: _____ Date of Birth: _____ Age: _____
Gender: Female Male Social Security #: _____
Referred By: _____ Primary Care Doctor: _____

Address: _____ City/State/Zip: _____
Home Phone #: _____ Cell #: _____ Work Phone #: _____
OK to leave message? YES NO YES NO YES NO

Mothers Name: _____ Date of Birth: _____ SSI#: _____
Address (if different than above): _____ City/State/Zip: _____
Phone # (if different than above): _____ Cell: _____ Okay To Leave Messages At These Numbers: **Yes** **No**
Mothers Employer: _____ Address: _____ Phone#: _____
Fathers Name: _____ Date of Birth: _____ SSI #: _____
Address (if different than above): _____ City/State/Zip: _____
Phone # (if different than above): _____ Cell: _____ Okay To Leave Messages At These Numbers: **Yes** **No**
Fathers Employer: _____ Address: _____ Phone#: _____

Person Responsible for Account: _____

PRIMARY INSURANCE

No Insurance Coverage
Insurance Co.: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
Client ID#: _____
Group/Plan #: _____
Policy Holder Name: _____
Date of Birth: _____ SS #: _____
Relationship to you: _____

SECONDARY INSURANCE

Insurance Co.: _____
Insurance Co. Address: _____

Insurance Co. Phone #: _____
Client ID#: _____
Group/Plan #: _____
Policy Holder Name: _____
Date of Birth: _____ SS #: _____
Relationship to you: _____

FOR OFFICE USE ONLY

Dates of Referral: _____ to _____ Date First Consulted: _____
Number of Sessions: _____ Ded.: _____ Co-pay/Co-ins: _____

Date	dx code	dx	Counselor Signature

Developmental History: (check all that apply for adolescent client)

Any Problems During or After Mother's Pregnancy?

- None
- Emotional Stress
- Alcohol Use
- Drug Use
- Cigarette Use
- Domestic Violence
- Postpartum Depression
- Other: _____

Birth: Normal Delivery Difficult Delivery Cesarean Delivery Complications: _____

Birth Weight: ____ lbs. ____ oz.

Infancy: Feeding Problems Sleep Problems Toilet Training Problems Attachment Problems

Delayed Developmental Milestones: (check all that apply)

- Sitting
- Rolling Over
- Crawling
- Standing
- Walking
- Feeding Self
- Speaking Words
- Speaking Sentences
- Controlling Bladder
- Controlling Bowels
- Dressing Self
- Engaging Peers
- Tolerating Separation
- Playing
- Riding Bicycle

Childhood Health: (check all that apply)

- Visual Problems
- Hearing Problems
- Problems with Coordination
- Physical, Sexual or Emotional Abuse
- Weight Loss/Gain
- Speech Problems
- Ear Infections
- Headaches
- Nausea/Vomiting
- Lead Poisoning
- Seizures
- Soiling/Bedwetting
- Head Injury
- Broken Bones
- Asthma
- Stomach Aches
- Allergies to: _____

Any Chronic or Serious Health Problems: _____

MEDICAL HISTORY

Describe Current Physical Health: Good Fair Poor

List All Medications Teen Is Taking. Include Non-Prescription Drugs And Health Supplements.

Drug Name	Purpose	Dosage	# Per Day
1.			
2.			
3.			

Prescribed By: _____

Do You Have Any Allergies To Medication? Yes No If yes, which ones? _____

Describe Any Hospitalization, Surgeries or Accidents

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

SUBSTANCE USE

Check Past or Current Substance Use:							
	Past Use	Current Use	How Often		Past Use	Current Use	How Often
Hard Liquor	<input type="checkbox"/>	<input type="checkbox"/>		Tranquilizers/Sleeping Pills	<input type="checkbox"/>	<input type="checkbox"/>	
Beer/Wine	<input type="checkbox"/>	<input type="checkbox"/>		Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>		Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	
Speed/Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>		Nicotine	<input type="checkbox"/>	<input type="checkbox"/>	
Heroin/Painkillers	<input type="checkbox"/>	<input type="checkbox"/>		Coffee	<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinogens/Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>		Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	
PCP	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	

Consequences of Substance Abuse: (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Hangovers | <input type="checkbox"/> Changes | <input type="checkbox"/> Binges |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of Control Amount Used | <input type="checkbox"/> Interference with School |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Job Loss |
| <input type="checkbox"/> Overdose | <input type="checkbox"/> Assaults | <input type="checkbox"/> Arrests |
| <input type="checkbox"/> Withdrawal Symptoms | <input type="checkbox"/> Suicidal Impulse | |
| <input type="checkbox"/> Medical Conditions | <input type="checkbox"/> Relationship Conflicts | |

Check Any of the Conditions Your Teen Has Had and the Date of Onset:					
Condition	Date	Condition	Date	Condition	Date
ADD/ADHD		Cancer		Learning Disability	
AIDS/HIV		Diabetic		Low Blood Pressure	
Allergies		Epilepsy		High Blood Pressure	
Anemia		Head Trauma		Obesity	
Arthritis		Heart Disease		Migraines	
Asthma		Hyperactivity		Stomach Ulcers	
Autism		Hypoglycemia		Thyroid Disease	
Asperger's		Panic Attacks		Skin Problems	
Depression		Anxiety Attacks		Obsessive/Compulsive	
Behavior Problems		Other:			

Check Any of The Following You Have Had In The Past Three Months:

- | | | |
|--|---|---|
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Weakness in Arms or Legs | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Nausea or Vomiting |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest Pains or Tightness | <input type="checkbox"/> Unusual Bleeding |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Irregularities |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Convulsion/Seizures | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Abnormal Growth or Lump |

Psychiatric History:

Prior **Outpatient** Therapy? Yes No Provider Name: _____ Was It Beneficial?: Yes No

Prior **Inpatient** Therapy? Yes No Facility Name: _____ Was It Beneficial?: Yes No

LIST OF CHILDREN BEHAVIORS: Please use the following scale to rate your child on each behavior. Indicate how often your child displays that behavior by circling the number which best describes the frequency of each behavior.

1
Never

2
Rarely

3
Occasionally

4
Frequently

5
Very Frequently

GROUP A

1	2	3	4	5	Has trouble Sleeping
1	2	3	4	5	Has Poor Appetite
1	2	3	4	5	Seems Sad or Unhappy
1	2	3	4	5	Talks About Feeling Stupid or Worthless
1	2	3	4	5	Loses Interest in Having Fun
1	2	3	4	5	Seems Irritable
1	2	3	4	5	Moody
1	2	3	4	5	Plays Alone
1	2	3	4	5	Cries Easily
1	2	3	4	5	Seems Tired

GROUP B

1	2	3	4	5	Complains About Physical Problems: Like Headaches or Stomachaches
1	2	3	4	5	Worries
1	2	3	4	5	Lacks Confidence in Their Abilities
1	2	3	4	5	Needs Lots of Reassurance
1	2	3	4	5	Needs to be Perfect
1	2	3	4	5	Seems Fearful and Anxious
1	2	3	4	5	Seems Shy or Timid
1	2	3	4	5	Easily Embarrassed
1	2	3	4	5	Sensitive to Criticism
1	2	3	4	5	Bites Fingernails

GROUP C

1	2	3	4	5	Always on The Go
1	2	3	4	5	Can't Sit Still
1	2	3	4	5	Doesn't Seem To Listen
1	2	3	4	5	Often Fails to Finish Things
1	2	3	4	5	Has Poor Concentration and Attention When Comes to Schoolwork
1	2	3	4	5	Often Fidgets with Hand/Foot or Squirms in Seat
1	2	3	4	5	Easily Distracted
1	2	3	4	5	Has a Hard Time Playing Quietly
1	2	3	4	5	Talks Excessively
1	2	3	4	5	Often Interrupts or "Butts In" to Others' Games
1	2	3	4	5	Seems Disorganized, Loses Things They Need For School
1	2	3	4	5	Takes Risks Without Considering The Danger Involved (e.g. Running into the Street Without Looking)
1	2	3	4	5	Blurts Out Answers to Questions Before They Have Been Completed

GROUP D

1	2	3	4	5	Refuses to Follow or do Chores
1	2	3	4	5	Loses Temper
1	2	3	4	5	Argues with Parents or Teachers
1	2	3	4	5	Blames Others for Their Mistakes
1	2	3	4	5	Swears
1	2	3	4	5	Deliberately Does Things to Annoy Other People
1	2	3	4	5	Is Angry or Resentful
1	2	3	4	5	Carries a grudge, Seems to have "A Chip on Their Shoulder"
1	2	3	4	5	Touchy, Easily Annoyed By Others

GROUP E

1	2	3	4	5	Steals
1	2	3	4	5	Runs Away Overnight
1	2	3	4	5	Lies
1	2	3	4	5	Skips School
1	2	3	4	5	Is Cruel to Animals
1	2	3	4	5	Destroys Property
1	2	3	4	5	Gets Into Fights
1	2	3	4	5	Has Been Physically Cruel to Other People
1	2	3	4	5	Doesn't Seem Sorry For Hurting Others
1	2	3	4	5	Sets Fires
1	2	3	4	5	Has Broken Into Someone Else's House or Car

GROUP F

1	2	3	4	5	Compulsive Behavior
1	2	3	4	5	Alcohol or Drug Use
1	2	3	4	5	Lack of Attachment
1	2	3	4	5	Dependent of Separation Problems
1	2	3	4	5	Self-Injury Acts
1	2	3	4	5	Self-Injury Threats
1	2	3	4	5	Indecisive
1	2	3	4	5	Immature
1	2	3	4	5	Odd Behavior
1	2	3	4	5	Upset with Physical Appearance
1	2	3	4	5	Sexual Behavior
1	2	3	4	5	Distrustful
1	2	3	4	5	Concerns Regarding Peer Influence
1	2	3	4	5	Teased or Bullied
1	2	3	4	5	Watches Television
1	2	3	4	5	Plays Video Games
1	2	3	4	5	Internet Use

Form Completed By: _____ **Date:** _____

General Information:

Has your teen experienced any serious upsets? YES NO If yes, what kind: _____

Has your teen suffered any significant losses? YES NO If yes, please explain: _____

Does your teen have any particular fears? YES NO Comments? _____

Any problems with sleeping? YES NO Comments? _____

Any problems with discipline? YES NO If yes, please describe: _____

How active is your teen? _____

List your teen's strengths: _____

Please add any information you feel would be helpful: _____

TREATMENT GOALS:

Please List Issues To Discuss In Therapy Which Are A Primary Concern And Specific Goals You Wish To Accomplish:
