



TRAVERSE COUNSELING AND CONSULTING

Traverse: To pass over, along or through

TEEN INTAKE FORM (ages 12-18)

Name: _____ Today's Date: ____/____/____
(Last) (First) (MI)

Birth Date: ____/____/____ Age: _____ Gender: Male Female Other: _____

Address: _____
(Street and Number) (City) (State) (Zip)

Clinician you are seeing today: _____

Parent/Guardian Name(s) & Info:

Parent # 1 Soc. Sec.#: _____ - _____ - _____ Phone: _____
May we leave a voice message? Yes No

E-mail: _____ May we email you? Yes No

Parent # 2 Soc. Sec.#: _____ - _____ - _____ Phone: _____
May we leave a voice message? Yes No

E-mail: _____ May we email you? Yes No

*Please note: Email correspondence is NOT considered a confidential medium of communication.

Teen lives with (check the appropriate box):

Mom Dad Both in same household haltime each parent other _____

Siblings:

Sib #1: _____ Age: _____ Sib #3: _____ Age: _____

Sib #2: _____ Age: _____ Sib #4: _____ Age: _____

School: _____ Grade: _____

Who referred you to Traverse Counseling & Consulting (if any)?: _____



TRAVERSE COUNSELING AND CONSULTING

Traverse: To pass over, along or through

Name: _____ Date of Birth: ____/____/____
(Last) (First) (MI)

School/Grade: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? No Yes (if yes, previous therapist/practitioner/school counselor): _____

Are you currently taking any prescription medication? Yes No (Please list): _____

Have you ever been prescribed psychiatric medication? Yes No (Please list and provide Dates): _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing: _____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing: _____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns: _____



TRAVERSE COUNSELING AND CONSULTING

Traverse: To pass over, along or through

5. Are you currently experiencing overwhelming sadness, grief or depression? No Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias? No Yes

If yes, when did you begin experiencing this? _____

How often? _____

7. Are you currently experiencing any physical pain? No Yes If yes, please describe:

8. How often do you drink alcohol? Daily Weekly Monthly Infrequently Never

Describe your use: _____

9. How often do you engage recreational drug use? Daily Weekly Monthly Infrequently Never

Describe your use: _____

10. How would you describe your digital life? Your relationship to your cell phone, internet, video games, computer, social media, etc. _____

11. Are you currently in a romantic relationship? No Yes

For how long? _____ On a scale of 1-10, how would you rate your relationship? _____

How would you describe your relationship? _____



TRAVERSE COUNSELING AND CONSULTING

Traverse: To pass over, along or through

12. Describe an average day at school, what goes well, what struggles do you have?: _____

13. What significant life changes or stressful events have you experienced? _____

FAMILY HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Accidental Death yes/no _____

Alcohol/Substance Abuse yes/no _____

Anxiety yes/no _____

Depression yes/no _____

Divorce/Separation yes/no _____

Domestic Violence yes/no _____

Eating Disorders yes/no _____

Head injury/trauma yes/no _____

Obesity yes/no _____

Schizophrenia yes/no _____

Suicide Attempts yes/no _____

Other family issues: _____



TRAVERSE COUNSELING AND CONSULTING

Traverse: To pass over, along or through

ADDITIONAL INFORMATION:

1. Are you currently employed? No Yes If yes, what is your current employment situation

Do you enjoy your work? What is most stressful about your current work? _____

2. Do you consider yourself to be spiritual or religious? No Yes

Describe your faith or belief: _____

3. What do you consider to be some of your strengths? _____

4. What do you consider to be some of your weakness? _____

5. What are your three most important values:

- _____

- _____

- _____

6. What is it that makes you feel *stuck*? _____

7. What would you like to accomplish out of your time in therapy? _____
