

# LAKEWOOD COUNSELING and Career Center

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lakewoodcounseling.com

## PARENT INTAKE FORM

Date: \_\_\_\_\_ Therapist: \_\_\_\_\_

Adolescent's Name: \_\_\_\_\_ Age: \_\_\_\_ Date of Birth: \_\_\_\_\_

Main purpose for contacting Lakewood Counseling (please give a brief summary):

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Parent's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ Home #: \_\_\_\_\_ Work#: \_\_\_\_\_  
Cell#: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Address: \_\_\_\_\_ Home #: \_\_\_\_\_ Work#: \_\_\_\_\_  
Cell#: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Parent's relationship: Married \_\_\_\_ Divorced \_\_\_\_ Never Married \_\_\_\_ Committed Partners \_\_\_\_  
State of the relationship: \_\_\_\_\_

Adolescent lives with which parents: Both equally \_\_\_\_ Primarily with \_\_\_\_\_  
Explain: \_\_\_\_\_

### Siblings:

Name \_\_\_\_\_ Age \_\_\_\_\_ Check One  
Biological Adopted Step Foster

Name	Age	Biological	Adopted	Step	Foster

Who lives together in the home(s), include pets:

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If adopted, significant aspects of the adoption:

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What birth family information is available:

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**Medical Information:**

Name of Adolescent's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Address: \_\_\_\_\_

Current medications (include dosages):  
\_\_\_\_\_  
\_\_\_\_\_

List any hospitalizations (include reason, age, length of time):  
\_\_\_\_\_  
\_\_\_\_\_

Current medical problems:  
\_\_\_\_\_  
\_\_\_\_\_

Any developmental concerns:  
\_\_\_\_\_  
\_\_\_\_\_

Please check the items that are important to address with your child in therapy. Consider each in terms of your adolescent's experience:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Friendships               | <input type="checkbox"/> Trouble concentrating/focus | <input type="checkbox"/> Self-esteem     |
| <input type="checkbox"/> Anger                     | <input type="checkbox"/> Mood swings                 | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> Eating habits             | <input type="checkbox"/> Grief and loss              | <input type="checkbox"/> Sleep issues    |
| <input type="checkbox"/> Behavior in school        | <input type="checkbox"/> Independent living skills   | <input type="checkbox"/> Physical health |
| <input type="checkbox"/> Relationship with parents | <input type="checkbox"/> Taking responsibility       | <input type="checkbox"/> Legal issues    |
| <input type="checkbox"/> School performance        | <input type="checkbox"/> Vocational issues           | <input type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Drug/alcohol use          | <input type="checkbox"/> Cultural issues             | <input type="checkbox"/> Gender issues   |
| <input type="checkbox"/> Sibling relationships     | <input type="checkbox"/> Sexual orientation          | <input type="checkbox"/> Bullying        |
| <input type="checkbox"/> Anxiety/worry             |  |  |

List the strengths of your adolescent:

What methods have you used to discipline your adolescent:

Which is most effective:

Has your adolescent been to therapy or counseling in the past? Yes \_\_\_ No \_\_\_

Was it helpful? Yes \_\_\_ No \_\_\_

What was the concern and how long did you attend counseling?

\_\_\_\_\_  
\_\_\_\_\_  
Therapist's Name: \_\_\_\_\_

Has your adolescent experienced physical abuse? No \_\_\_ Yes \_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

Has your adolescent experienced neglect? No \_\_\_ Yes \_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

Has your adolescent experienced sexual abuse? No \_\_\_ Yes \_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

Has your adolescent experienced emotional abuse? No \_\_\_ Yes \_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

Has your adolescent ever talked about suicide or made an attempt? No \_\_\_ Yes \_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

Has your adolescent ever talked about or physically hurt an animal or another human being? No \_\_\_ Yes \_\_\_

Explain: \_\_\_\_\_  
\_\_\_\_\_

Are there areas of concern about your adolescent's school experience?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are the stressors on your adolescent (i.e. family death, illness, unemployment, divorce, change in school, friendships, etc.)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any other information you would like to share?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you!