

JAKE LEHRER, M.A., LMFT

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Adolescent Intake Form

Name: _____ Age: _____ Cell #: _____

Please answer these questions as completely as possible. You can discuss any topic more fully when you meet your therapist. It is your choice whether or not you answer any specific question(s). The purpose of this form is to help your therapist understand you, your background, and your concerns. This will not be shared with anyone else parents. THIS IS FOR YOUR THERAPIST ONLY.

Please describe the issue or concern that brings you to therapy, including specific symptoms or problems you MOST want to address:

Check any of the following statements that are true for you. USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.

- I've been told or think I have ADD/ADHD
- Others have expressed worry about my eating habits
- I get angry a lot
- I worry often
- I think about hurting or killing myself
- At times, my life or future seems hopeless
- I'm comfortable with my eating habits
- My parents think I sleep too much
- Thoughts seem to race in my head a lot
- I have a hard time concentrating when I need to
- My energy levels are lower than I'd like
- I get frustrated easily
- My mood seems to go up and down quickly and/or severely
- I avoid conflict
- I feel stressed a lot
- I feel successful about school
- I cry quite a lot
- I get angry and I don't know why
- I feel guilty about things often

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Check any of the following statements that are true for you. *USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.*

- I get sad for no reason
- I'm scared at home and/or school
- I get all of my homework done on time
- I'm bored with school
- I have trouble falling and/or staying asleep
- Myself or others have said they think I sleep too much
- I have good friends
- I feel supported by my family
- My parents do not like my friends
- I'm happy with my success in school
- I feel people in my family do not care about me
- My parents and I get along pretty well
- My siblings and I get along fine
- My friends have said that they worry about me
- My parents put too much pressure on me
- I worry about someone in my family
- There is a lot of conflict in my house
- My parents are too controlling
- I have trouble making or keeping friends
- I like myself
- I know what I am good at
- I feel my strengths outweigh my weaknesses
- I feel comfortable at my school
- I am comfortable with my looks
- My weight is an issue for me
- I wish I could change certain things about me or my life or family
- I am sexually active
- I have concerns about certain sexual things
- My parents and/or friends express worry about my sexual activity

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Check any of the following statements that are true for you. USE SPACE NEXT TO STATEMENT TO PROVIDE MORE INFORMATION, IF YOU WISH.

- I am often very jealous of certain people and it bothers me / others
- I am NOT clear about my sexual orientation and/or gender (gay, straight, bisexual, transgender)
- I like being in committed relationships
- My culture, religion, and/or ethnicity is an issue for me
- I have experience with drugs and alcohol
- I currently use drugs and/or alcohol
- Others have expressed worry or concern about my use of drugs and/or alcohol
- I have been in trouble with the legal system before
- I am concerned about someone else's use of drugs and/or alcohol
- Sometimes I think I overuse the internet, videogames, etc.
- Sometimes I think I overuse pornography or I may have a pornography addiction
- My parents think I am addicted to screens/electronics

Are you currently having any other *specific* problems at work, school, home? Please describe:

Chemical Health History (Alcohol, Illegal Substances, Non-Prescribed Substances, Tobacco, other)

Substance	Age When 1 st Tried	Date of most recent Use	Frequency of Use in Last Six Months (how often)	Amount Used Typically

Have there been any negative consequences as a result of your chemical use? i.e., DUI's, arrests, charges, relationship difficulties, etc. If yes, please describe.

Previous chemical abuse treatments? Describe (where, when, comments):

OVER →

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My personal strengths:

My personal challenges/weaknesses:

Losses I have experienced (Who/What?... ..When?..... How/Why?.)

Something that I would change about my family:

What do you want to get out of therapy?

Would doing family therapy be helpful in addition to your individual therapy? How? What issues would YOU address in family therapy?

Is there anything else you want to share?:

THANK YOU