

PARENT INTAKE FORM

Date: _____ Therapist: _____

Adolescent's Name: _____ Age: ____ Date of Birth: _____

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

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

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

If adopted, significant aspects of the adoption:

What birth family information is available:

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