PARENT INTAKE FORM

Date: _____ Therapist: _____

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

Main purpose for contacting Brian Ross (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:

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

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