Dr. Angela Reiter & ASSOCIATES

Adolescent Intake Information Form

PERSONAL INFORMATION

Name: _____ Age: _____ Birthdate: _____

Address: _____

Home Phone Number: _____ Mobile Phone Number: _____

Email Address: _____

Mother's Name: _____

Father's Name: _____

Stepparent's Name(s): _____

Brother/sister/stepbrother/stepsister Name(s) and Age(s): _____

_____

Emergency Contact Information:

Name	Relationship	Phone Number

Do you get along with your parents or stepparents? YES NO Why or why not?

_____

_____

_____

Do you get along with your siblings or stepsiblings? YES NO Why or why not?

_____

_____

_____

Which school do you go to? _____ What grade are you in? _____

How are your grades? Not good Okay Good Very good

What problems do you have in school?

_____

_____

Do you get in fights or get picked on at school or at home? YES NO If yes, please explain:

_____

_____

_____

How many close friends do you have? _____

Do you have a serious relationship now? YES NO

Do you work? YES NO Where? _____

Do you have any hobbies? YES NO What? _____

What makes you happy? _____

_____

What worries or upsets you?

_____

_____

List some of your good qualities (things you like about yourself):

_____

_____

_____

CURRENT HEALTH

Height: _____ Weight: _____

How would you rate your physical health? Poor Average Good

Do you have any physical disabilities? Yes No If so, describe: _____

Do you have any specific medical conditions that concern you? Yes No If yes, describe:

_____

_____

Have you received treatment for these conditions? Yes No

Do you have problems sleeping? Yes No

If so, what types of problems? Difficulty falling asleep Wake often Poor Sleep Habits

Other: _____ Have

you experienced any recent changes in your appetite? Yes No

Have you ever had concerns about having an eating disorder? Yes No

How often do you exercise? Very Little 1-2 times a week 3-4 times a week Daily

What type(s) of exercise do you engage in? _____

How would you rate your alcohol consumption? None Light Moderate Heavy

Do you ever consume more than 5 drinks in one setting? Yes No How often?

_____ Do you use other recreational or illegal drugs? Yes No What do you do for fun or for relaxation?

_____

How would you rate your social life? Poor Average Good

Please circle items of concern to you:

Anxiety/Nervousness

Shyness

Social Problems

Stress

Anger

Explosive temper

Low Energy

High Energy

Unhappy most of the time

Cry too often

Sadness

Difficulties concentrating

Loneliness

Low self confidence

Low self esteem

Fear making mistakes

Thoughts of cutting or burning myself

Obsessive thoughts

Unusual thoughts

Unclear Self Image

Excessive Guilt

Study Habits

Employment Issues

Difficulties Trusting Others

Belonging to a minority group

Concerns about my religious beliefs

Daydreaming

Hearing or seeing things that others do not hear or see

Body image

Concerns about my weight

Sexual problems

Sexual identity

Arguments with significant other Break up of important relationship

Death of a significant other

Death of a pet

Career concerns

Academic concerns

Financial concerns

Legal concerns

Frequent headaches

Frequent stomachaches

Frequent illness

Family member's psychological problems

Family member's alcohol or drug use Family members suicide

Do you have thoughts of harming or killing yourself?

YES NO

Have you ever attempted suicide? YES NO

When?

_____

Do you have thoughts of harming another person?

YES NO

Please describe other health concerns you have:

_____

_____

Current medications you are taking (please print):

_____

COUNSELING INFORMATION

Have you been to counseling before? YES NO When? _____

What for? _____

Did you enjoy it? YES NO Why or why not?

_____

_____

_____

Why do you think you are coming to see me?

_____

_____

_____

If you came to see me for psychotherapy (not testing), what would you like to change in therapy?

_____

_____

_____

What else is important for me to know?

_____

_____

_____

Signature: _____ Today's Date: _____

Patient Signature

Name [Please print]:_____

The information contained in this self-report was reviewed with the patient.

_____ _____

Clinician Signature Date