GOLDEN SKY
COUNSELING
Rikki Goldenberg, LMHC

Adolescent Intake Questionnaire

Today's Date _____

Name _____ Date of Birth _____

Who referred you to me? How did you find me as your therapist (e.g., friend recommendation, doctor referral, Google search, provider directory search, etc.)?

_____

_____

What is the reason you are coming in for counseling? Is there something specific, such as a particular event? Please be as detailed as you can.

_____

_____

_____

What are your goals for our work together? What do you hope to gain out of counseling?

_____

_____

_____

Who currently lives in your home with you? (Name, Relation, Sex, Age)

_____

_____

What is the highest grade level you have completed so far? _____

What school do you attend currently and what kinds of grades do you get in school?

_____

_____

Have you had any disciplinary problems at school?

- ☐ Yes _____
- ☐ No

<u>Sleep and Nutrition</u>

How many hours of sleep do you typically get? Do you feel rested when you wake up? If not, please explain.

_____

_____

Do you eat regular meals throughout the day?

- ☐ Yes, always
- ☐ Sometimes
- ☐ Rarely, I mostly snack

Social

What do you like to do for fun or enjoyment? Do you have any hobbies?

_____

_____

_____

Do you have close sources of support or an "inner circle?" If yes, who are they? First names or relation to you only, please.

_____

_____

Approximately how many hours per day do you spend on electronics?

_____

_____

Do you currently drink alcohol?

- ☐ Yes, how often? _____
- ☐ No

Do you smoke cigarettes or use any nicotine products?

- ☐ Yes, how often? _____
- ☐ No, I don't use any nicotine products.

Have you used any recreational drugs in the past 6 months?

- ☐ Yes, how often? _____
- ☐ Have used in the past, but not in the past 6 months
- ☐ Never used

Have you experienced any legal problems or been arrested?

- ☐ Yes _____
- ☐ No

Medical History

Who is your primary care doctor? Please include your doctor's name and phone number.

_____

_____

On a scale from 0 to 10 (0=very poor, 10=the very best), how would you rate your health and why?

_____

_____

Please check if you have experienced any of the following:

- ☐ Migraines
- ☐ Stomach issues
- ☐ Hormone-related problems
- ☐ Head injury
- ☐ Chest pain
- ☐ Chronic pain
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Chronic fatigue
- ☐ Fibromyalgia
- ☐ Shortness of breath
- ☐ Diabetes
- ☐ Asthma
- ☐ Thyroid issues
- ☐ Cancer
- ☐ Other
- ☐ None of the above

Have you had any major surgeries, illnesses or accidents? if yes, please specify and include the date and what happened.

- ☐ Yes _____
- ☐ No

Do you have any allergies? If yes, please specify.

- ☐ Yes _____
- ☐ No

Are you taking any prescription medications?

- ☐ Yes _____
- ☐ No

Developmental and Childhood History

Where were you born? _____

Where did you grow up? _____

Who did you live with?

_____

How would you describe your childhood so far?

_____

_____

_____

How do your parent(s)/guardian(s) discipline you? What happens if you break the rules or get into trouble?

_____

_____

Emotional and Behavioral History

Please check any of the following you have experienced in the past 6 months:

- ☐ Difficulty falling or staying asleep
- ☐ Difficulty getting out of bed
- ☐ Frequent nightmares
- ☐ Changes in eating/appetite
- ☐ Voluntary vomiting
- ☐ Use of laxatives to lose weight
- ☐ Binge eating
- ☐ Excessive exercise to avoid weight gain
- ☐ Persistent loss of interest in previously enjoyed activities
- ☐ Withdrawing from other people
- ☐ Spending more time alone
- ☐ Increased irritability
- ☐ Feeling anxious
- ☐ Panic attacks
- ☐ Frequent feelings of guilt
- ☐ Difficulty leaving your home
- ☐ Fear of certain objects or situations
- ☐ Repetitive behaviors (counting, checking doors, washing hands)
- ☐ Outbursts of anger
- ☐ Feelings of worthlessness
- ☐ Sadness
- ☐ Fear
- ☐ Tearful or crying spells
- ☐ Hopelessness
- ☐ Low self-esteem
- ☐ Frequent worry
- ☐ Racing thoughts
- ☐ Difficulty catching your breath
- ☐ Easily startled, feeling "jumpy"
- ☐ Difficulty concentrating or thinking
- ☐ Flashbacks of negative events
- ☐ Large gaps in memory
- ☐ Hearing voices when no one else is present
- ☐ Feeling that your thoughts are controlled or placed in your mind
- ☐ Feeling that the television or radio is communicating with you
- ☐ Feeling as if you were outside yourself, detached, observing what you are doing
- ☐ Verbal abuse
- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Other
- ☐ None of the above

Is there a history of mental illness in your family? If yes, please specify their relation to you as well as their diagnosis if you know it.

- ☐ Yes
  _____
  _____
- ☐ No
- ☐ I'm not sure

Have you participated in therapy before? If yes, please specify when, the name of the therapist, the reason for seeking help, and if you found it helpful.

- ☐ Yes _____
- ☐ No

Have you ever been hospitalized for a psychiatric issue?

- ☐ Yes _____
- ☐ No

Do you have, or have you ever had suicidal thoughts?

- ☐ Yes _____
- ☐ No

Have you ever attempted suicide? Please list all attempts and your age when each happened, starting from the most recent event to the oldest event.

- ☐ Yes _____
- ☐ No

Do you have, or have you ever had, a problem with self-harm (e.g., cutting, scratching, hair-pulling, etc.)?

- ☐ Yes _____
- ☐ No

Do you have, or have you ever had thoughts or urges to harm someone else or damage their property?

- ☐ Yes _____
- ☐ No

Are you taking any psychotropic medications?

- ☐ Yes _____
- ☐ No

More About You

What are some of your goals for yourself over the next 3 -6 months?

_____

_____

_____

What else would you like me to know?

_____

_____

_____

_____