Adolescent Intake Form

Mental Health Matters, LLC
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Name:____ DOB:________________ Age:______________

Male:______ Female:_______Transgender:_______Gender Fluid:_______Other:_________ Race:________________

School Name/Address:____

Grade:________________ Teacher:_____________________________ Today's Date:______________________

People living in same household as adolescent:

Name	Age	Relationship to Adolescent
_______________________________________	___________	_____________________________
_______________________________________	___________	_____________________________
_______________________________________	___________	_____________________________
_______________________________________	___________	_____________________________
______________________________________	___________	_____________________________

Other significant people NOT living in the same household:

Name	Age	Relationship to Adolescent
_____________________________________	__________	____________________________
_____________________________________	__________	____________________________
____________________________________	__________	____________________________
____________________________________	__________	____________________________

Has your child previously been or are they currently under the care of a psychiatrist? Y______ N______

Name/Address/ Phone of Psychiatrist:____

____

Has your child previously ever been hospitalized? Y_________ N_________

If yes, for what, where and when?____

Treating Physician's Name:____

Is your child currently on medication? Y____________ N____________

Name of Medication	Reason for Medication	Dosage	Prescribing Physician
____________________	__________________________	_______________	_________________
____________________	__________________________	_______________	_________________
____________________	__________________________	_______________	_________________

Name/Phone of primary care physician or pediatrician:____

____

Check any areas where your teen is having any problems:

___weight/eating/diet ___health ___sexual acting-out ___suicidal thoughts ___nervous habits

___social/friendships ___behavior ___self-harm ___getting along with adults ___sleeping

___drug use ___mood swings ___depression ___anxiety ___sexual identity ___gender identity

__hygiene ___school ___language skills __delinquent behavior ___separation anxiety __other

List other:____

Briefly explain the items you checked:____

____

____

Are there any other concerns?

____

____

____

____

What reinforcements do you use with your child?

____

____

____

Describe the discipline used in the home.

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