CENTURY MENTAL HEALTH, INC.

5570 Sterrett Place, Suite 101 * Columbia, Maryland 21044
Tel: 410.730.0552 * Fax: 410.715.4720

ADOLESCENT INTAKE FORM PARENT SECTION

Please note that the information is important for your care. Please fill out forms as completely as possible and have them ready before the first therapy session. These forms will remain confidential unless subpoenaed by a court.

Parent(s) Name(s): _____

Parent(s) Phone number(s)_____

Adolescent's Name: _____

Adolescent's Date of Birth: _____

PRESENTING ISSUES

Briefly describe the presenting issue(s) for which you are seeking therapy for your adolescent.

_____

_____

_____

What would you like to see happen as a result of therapy?

_____

_____

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child? ❒ Yes ❒ No

If yes, please describe:

_____

_____

Did your child have health problems at birth? ❒ Yes ❒ No

If yes, please describe:

_____

_____

Has your child experienced any developmental delays (e.g. toilet training, walking, talking)?

❒ Yes ❒ No ❒ Unsure If yes, please describe:

_____

_____

Did your child display any developmentally unusual behaviors or problems prior to age 3?

❒ Yes ❒ No ❒ Unsure

yes, please describe:

_____

_____

Has your child experienced emotional, physical, or sexual trauma? ❒ Yes ❒ No ❒ Unsure

If yes, please describe:

_____

TREATMENT/MEDICAL HISTORY

Has your child previously seen a therapist ? ❒ Yes ❒ No

If yes, where: _____

Approximate dates of counseling: _____

For what reason(s) did your child attend therapy? _____

Has your child accessed psychiatric services? ❒ Yes ❒ No

If yes, where: _____

Has your child been treated at a higher level of care for mental health reasons? (e.g. inpatient, residential, partial, intensive outpatient program?)_____

Does your child have a previous mental health diagnosis? ❒ Yes ❒ No ❒ Unsure

If yes, please specify:

_____

What did you find most helpful about their treatment?

_____

_____

What did you find least helpful about their treatment?

_____

_____

Has your child taken medication for a mental health concern? ❒ Yes ❒ No

If yes, please indicate names, dosages, and dates:

_____

_____

_____

Does your child have other medical concerns or previous hospitalizations? ❒ Yes ❒ No

If yes, please describe.

_____

_____

SUBSTANCE USE

Do you have any concerns with your son or daughter using alcohol or drugs?

❒ Yes ❒ No If yes, please explain your concern:

_____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your child using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? ❒ Yes ❒ No If yes, please explain your concern:

_____

_____

_____

LEGAL ISSUES

Please list any legal issues that are affecting you, your family, or your child (at present, or have had a significant effect in the past).

_____

_____

SCHOOL HISTORY

Do you have any current concerns relating to your child's education? ❒ Yes ❒ No

If yes, please explain your concern:

_____

_____

Does your child receive special education services through their school system?

❒ Yes ❒ No ❒ IEP ❒ 504 Plan ❒ Speech ❒ OT ❒ PT

FAMILY HISTORY

Did either parent experience any abuse/trauma as a child in their home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____

_____

_____

Did either parent experience any abuse/trauma in their adult life (physical, verbal, emotional, or sexual)? Please describe as much as you feel comfortable.

_____

_____

_____

Please list all of the people in what you would describe as your immediate family:

NAME RELATIONSHIP TO CHILD AGE GENDER LIVING W/CHILD?

_____

_____

_____

_____

PARENT'S MARITAL STATUS (This question refers to the parents relationship.

Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent, if applicable.)

❒ Single ❒ Married (legally) ❒ Divorced ❒ Co-habitating ❒ Divorce in process ❒ Separated ❒ Widower

❒ Remarried (mother) ❒ Remarried (father) ❒ Other

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

Parent's Name: _____Birth Date:_____ Age: _____

Occupation: _____Place of Employment: _____

Military experience? ❒ Yes ❒ No Current Status ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

❒ Other

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Parent's Name: _____Birth Date:_____ Age: _____

Occupation: _____Place of Employment: _____

Military experience? ❒ Yes ❒ No

Current Status ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Other

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Please note any custody concerns/arrangements if applicable:

_____

_____

FAMILY MENTAL HEALTH HISTORY

In the section below, identify if there is a family history of any of the following.

If yes, please indicate the family member's relationship to your child (e.g. father, maternal grandmother, uncle, etc.) ❒ Alcohol/substance abuse ❒ Anxiety ❒ Depression ❒ Domestic Violence

❒ Eating disorders ❒ Obsessive compulsive behavior ❒ Major mental illness ❒ Suicide attempts

❒ Psychiatric hospitalizations

❒ Other _____

List family member(s): _____

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

❒ Fighting ❒ Disagreeing about relatives ❒ Feeling distant ❒ Disagreeing about friends

❒ Loss of fun ❒ Alcohol use ❒ Lack of honesty ❒ Drug use ❒ Physical fights ❒ Education problems

❒ Divorce/separation ❒ Financial problems ❒ Issues regarding remarriage

Death of a family member ❒ Birth of a sibling ❒ Abuse/neglect ❒ Birth of a child

❒ Inadequate housing Other concerns not listed above:

_____

_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your child enjoys?

_____

_____

What positive personal qualities does your child have?

_____

_____

Who are some of the influential and supportive people, activities or beliefs in your child's life?

Please describe:

_____

_____

Is there anything else you would like to share?

_____

_____

_____

Please circle any symptoms you believe your child may be experiencing:

SADNESS
CRYING
PROBLEMS AT HOME
HYPERACTIVITY
BINGING/PURGING
LONELINESS
UNRESOLVED GUILT
IRRITABILITY
NAUSEA/INDIGESTION
SOCIAL ANXIETY
SELF HARM/CUTTING
IMPULSIVITY
NIGHTMARES
HOPELESSNESS
ELEVATED MOOD
MOOD SWINGS
ANOREXIA
GRIEF
PHOBIAS
HEADACHES
CHANGE IN WEIGHT
CHANGE IN APPETITE
DIFFICULTY SLEEPING
ISSUES WITH BODY/WEIGHT
SOCIAL ISOLATION
PARANOID THOUGHTS
INDECISIVENESS
LOW ENERGY
EXCESSIVE WORRY
POOR CONCENTRATION
LOW SELF WORTH
ANGER ISSUES
IDENTITY QUESTIONS
HALLUCINATIONS
RACING THOUGHTS
RESTLESSNESS
DRUG USE
ALCOHOL USE
EASILY DISTRACTED
TRAUMA FLASHBACKS
OBSESSIVE THOUGHTS
PANIC ATTACKS
FEELING ANXIOUS
FEELING PANICKY
SUICIDAL THOUGHTS
HOMICIDAL THOUGHTS
OTHER

Special Confidentiality Notice for Parents

We strongly believe that for therapy to be helpful to an adolescent, there needs to be as much confidentiality for them as possible in the therapy process. That is, unless the issue falls into the following categories…

--your child is clearly unsafe or at risk of harming themselves

--your child is at risk of being harmed by anyone else

--your child is at risk of harming someone else

--we are required by a court to disclose treatment records

…in which case we would follow the clinically and legally appropriate reporting requirements. Outside of this, we will encourage your child to express themselves freely, and assure them that there will be confidentiality provided to them in this process. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is facing, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you, and we are happy to facilitate family meetings whenever helpful and appropriate.