# CENTURY MENTAL HEALTH, INC.

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## ADOLESCENT INTAKE FORM

*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.*

### CLIENT INFORMATION

Name: ________________________________________________________________

Date of Birth: _____________________________ Age: _______

Gender:_____________ Preferred pronouns: ____________________

Phone (Cell): _______________________Can we leave messages at this number?__________

School: ____________________________________________Grade: ________________

### CURRENT REASON FOR SEEKING THERAPY

Why are you coming to therapy?

______________________________________________________________________

______________________________________________________________________

How do you think therapy might help you?

______________________________________________________________________

______________________________________________________________________

### PERSONAL STRENGTHS

What activities do you enjoy?

______________________________________________________________________

______________________________________________________________________

What qualities are you proud to share with others? (e.g. kindness, intelligence)

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

### THERAPY/TREATMENT HISTORY

Have you previously seen a therapist? ❒ Yes ❒ No

If yes, what did you find most helpful in therapy?

______________________________________________________________________

______________________________________________________________________

If yes, what did you find least helpful in therapy?

________________________________________________________________________

________________________________________________________________________

**SUBSTANCE USE AND HISTORY**

Do you currently use alcohol? ❒ Yes ❒ No

If yes, how often do you drink? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

If yes, how much do you drink? ___________(#) per time.

Do you currently use tobacco? ❒ Yes ❒ No

If yes, how often do you smoke/chew? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

Do you currently use marijuana? _____________________________

Do you currently use any other drugs? ❒ Yes ❒ No

If yes, what kind?

________________________________________________________________________

If yes, how often do you use? ❒ Daily ❒ Weekly ❒ Occasionally ❒ Rarely

**FAMILY INFORMATION**

Are your parents married, divorced or separated? ____________________________________

Do you think their relationship is good? ❒ Yes ❒ No ❒ Unsure

If your parents are divorced, whom do you primarily live with? __________________________

Were you adopted? ❒ Yes ❒ No

**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

Other concerns not listed above:

________________________________________________________________________

**PEER RELATIONS**

How do you consider yourself socially? ❒ Outgoing ❒ Shy ❒ Depends on the situation

Are you happy with the amount of friends you have? ❒ Yes ❒ No

Have you ever been bullied? ❒ Yes ❒ No If yes, please describe: ____________________________

______________________________________________________________________________

______________________________________________________________________________

Are your parents happy with your friends? ❒ Yes ❒ No

Are you involved in any organized social activities? (e.g. sports, music)?

______________________________________________________________________________

______________________________________________________________________________

**SCHOOL HISTORY**

On a scale of 1-10 (10 being the most) how much do you enjoy school? ____________________

Do you attend regularly? ❒ Yes ❒ No

Generally, how are your grades? ____________________________________________________________

Have there been any significant changes in your grades? ❒ Yes ❒ No

Do you feel you are doing the best you can at school? ❒ Yes ❒ No ❒ Unsure

**INDIVIDUAL CONCERNS**

Is there anything else you would like to share?

______________________________________________________________________________

______________________________________________________________________________

Please place a checkmark in the appropriate place for each of the following you might be experiencing:

| SYMPTOM | NONE | MILD | MOD | SEVERE | SYMPTOM | NONE | MILD | MOD | SEVERE |
|---|---|---|---|---|---|---|---|---|---|
| SADNESS | | | | | SOCIAL ISOLATION | | | | |
| CRYING | | | | | PARANOID THOUGHTS | | | | |
| PROBLEMS AT HOME | | | | | INDECISIVENESS | | | | |
| HYPERACTIVITY | | | | | LOW ENERGY | | | | |
| BINGING/PURGING | | | | | EXCESSIVE WORRY | | | | |
| LONELINESS | | | | | POOR CONCENTRATION | | | | |
| UNRESOLVED GUILT | | | | | LOW SELF WORTH | | | | |
| IRRITABILITY | | | | | ANGER ISSUES | | | | |
| NAUSEA/INDIGESTION | | | | | IDENTITY QUESTIONS | | | | |
| SOCIAL ANXIETY | | | | | HALLUCINATIONS | | | | |
| SELF HARM/CUTTING | | | | | RACING THOUGHTS | | | | |
| IMPULSIVITY | | | | | RESTLESSNESS | | | | |
| NIGHTMARES | | | | | DRUG USE | | | | |
| HOPELESSNESS | | | | | ALCOHOL USE | | | | |
| SYMPTOM | NONE | MILD | MOD | SEVERE | SYMPTOM | NONE | MILD | MOD | SEVERE |

MOOD SWINGS

ANOREXIA

GRIEF

PHOBIAS

HEADACHES

CHANGE IN WEIGHT

CHANGE IN
APPETITE

DIFFICULTY SLEEPING

ISSUES WITH
BODY/WEIGHT

TRAUMA
FLASHBACKS

OBSESSIVE
THOUGHTS

PANIC ATTACKS

FEELING
ANXIOUS

FEELING
PANICKY

SUICIDAL
THOUGHTS

HOMICIDAL
THOUGHTS

OTHER