Thank you so much for filling out this form.
Adolescents please fill out pages1-4 and Parents 5-10.
If you have any questions or would prefer not to answer questions, please talk to me about it in session.

Audrey Oxenhorn, LCSW,
Love Makes A Family LLC
www.audreyoxenhorn.com

ADOLESCENT INTAKE FORM (ages 12-17)
CLIENT INFORMATION –DATE_____
Name:_____
_____ Date of Birth: _____
Age: _____ ❒ Male ❒ Female
Physical Address:
_____
_____
Mailing Address:
_____
_____
Phone (Cell):
_____Messages ?
Phone (Home): _____Messages ?
School: _____
_____
Grade: _____
Race/Ethnic Origin:
_____
Religious Preference:
_____
PERSONAL STRENGTHS
What activities do you enjoy and feel you are successful when you try?
_____
_____
_____
Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)
_____

_____
_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking counseling?

_____
_____
_____

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

_____
_____
_____
_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ❒Yes ❒No

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

_____
_____
_____

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

_____
_____
_____

CHEMICAL 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 much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes _____No

If yes, what drugs do you use?

_____ If yes, how often do you use? _____Daily _____Weekly _____Occasionally _____Rarely

Have you received any previous treatment for chemical use? Y/N

_____

If so, where did you go?

____Inpatient ____Outpatient

ADOLESCENTS (please answer the following with Y/N)
Have you ever used more than 1 chemical at the same time to get high? _____
Do you avoid family activities so you can use? _____
Do you have a group of friends who also use? _____
Do you use to improve your emotions such as when you feel sad or depressed?? _____
LEGAL ISSUES
Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon you in the past.

_____
_____
FAMILY HISTORY
Are your parents married or divorced? _____
Do you think their relationship is good? (Y/N/Unsure)_____
If your parents are divorced, whom do you primarily live with?

_____
How often do you see each parent? Mom_____% Dad _____%.
Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

_____
_____
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 or Drug use
- Lack of honesty

Trauma
Medical Concerns
Infidelity (couple)
Education problems
Divorce/separation
Financial problems
Issues regarding remarriage
Death of a family member
Birth of a child
Inadequate health insurance
Job change or job dissatisfaction
Inadequate housing/feeling unsafe
Other

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? (Y/N)_____

Have you ever been bullied? (Y/N) _____

Are your parents happy with your friends? (Y/N)_____

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

_____

_____

SCHOOL HISTORY

Do you like school? (Y/N)_____

Do you attend regularly? (Y/N)_____

What are your current grades? _____

Do you feel you are doing the best you can at school? (Y/N)

_____

Is there anything else you would like me to know:

_____

_____

_____

_____

_____

Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)
Adolescent's Name:
_____Date of Birth:
_____ Mother's/Guardian's Name: _____
Phone Contact:_____ Mother's/Guardian's Physical Address: _____
Mother's/Guardian's Mailing Address:
_____
Father's/Guardian's Name: _____ Phone Contact:_____ Father's/Guardian's Physical Address:
_____
Father's/Guardian's Mailing Address:
_____
CURRENT HOUSEHOLD AND FAMILY INFORMATION

- Name
- Relationship (parent, sibling, etc)
- Age
- Sex
- Type (bio, step, etc)
- Living with you? Y/N

(If additional space is need please list on the back of page)
Current Reason For Seeking Counseling For Your Adolescent
Briefly describe the problem for which your adolescent is seeking to have counseling for?
_____
_____
_____
What would you like to see happen as a result of counseling?
_____
_____
_____

What is most concerning right now?

_____
_____
_____
_____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor?❒Yes❒No
If Yes, where:

_____
_____

Approximate Dates of Counseling:
_____ For what reason did your son or daughter go to counseling?

_____
_____
_____
_____

Does your son or daughter have a previous mental health diagnosis?

_____

What did you find most helpful in therapy?

_____
_____
_____
_____

What did you find least helpful in therapy?

_____
_____
_____
_____

Has your son or daughter used psychiatric services? Yes____ No____ If yes, who did they see?

_____
_____

If yes, was it helpful? N/A____ Yes____ No_____
Has your son or daughter taken medication for a mental health concern? Yes_____ No _____ Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe:

_____
_

CHILD'S DEVELOPMENT

Were there any complications with the pregnancy or delivery of your child?
Yes ___ No ___ If yes, describe:

_____
_____
_____

Did your child have health problems at birth? Yes _____ No _____ If yes, describe:

_____
_____
_____
_____

Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
Yes ___ No ___ Not sure_____ If yes, describe:

_____
_____

Did your child have any unusual behaviors or problems prior to age 3?
Yes ___ No ___ Not sure_____ If yes, describe:

_____
_____

Has your child experienced emotional, physical, or sexual abuse?
Yes ____ No ____ Not sure _____ If yes, describe:

_____
_____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____
If yes, please explain your concern:

_____
_____
_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____
If yes, please explain your concern:
_____
_____
LEGAL ISSUES
Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past.
_____
_____
_____
FAMILY HISTORY
(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.)
Father's Name: _____Birth Date:_____
Age: _____
Ethnic Origin:
_____
Total years of education completed: _____ Occupation:
_____ Place of Employment:
_____
Military experience? Y/N _____ Combat experience? Y/N
_____ Assessment of current relationship if applicable:
Poor_____ Fair_____ Good_____ Mother's Name:
_____Birth Date:_____ Age: _____
Ethnic Origin:
_____
_____ Total years of education completed: _____ Occupation:
_____ Place of Employment:
_____
Military experience? Y/N _____ Combat experience? Y/N
Assessment of current relationship if applicable: Poor_____ Fair_____
Good_____
PARENT'S MARITAL STATUS

❒Single❒Married (legally)❒Divorced❒Cohabitating❒Divorce in process❒Separated ❒Widowed❒Other

_____

Length of marriage/ relationship:_____
If divorced, how old was your child at time of divorce? _____
If divorced, How much time does your child spend with each parent?
Mother_____%, Father _____%

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 or Drug use
- Lack of honesty
- Trauma
- Medical Concerns
- Infidelity (couple)
- Education problems
- Divorce/separation
- Financial problems
- Issues regarding remarriage
- Death of a family member
- Birth of a child
- Inadequate health insurance
- Job change or job dissatisfaction
- Inadequate housing/feeling unsafe
- Other_____

Have you or anyone in your family experienced any abuse (physical, verbal, emotional, or sexual) inside or outside of your home? Please describe as much as you feel comfortable.

_____
_____
_____

Have you or anyone in your family been treated for issues relating to depression, anxiety, suicide or other mental health disorders? If so, please describe:

_____

_____

_____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

_____

_____

_____

What personal qualities would you say your son or daughter has?

_____

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

_____

_____

_____

Is there anything else you would like me to know:

_____

_____

_____

_____