Aquiline Counseling
Sandy Tudor, MA, LMHC
Adolescent (13 through 17 Years of Age) Intake Sheet

Today's Date:______________________________

To be filled out by client. Please fill out as much as possible.

Client Name; First______________________________ Last______________________________Middle Initial_____

Parent's Names:____

Address____City________________________Zip_________

Home Phone______________________________________ Cell Phone___________________________________

Work Phone____________________Email____

Acceptable Forms of Communication & Leaving Messages: (check those that are acceptable)

Home Phone____ Cell Phone____ Work Phone____ Email____ Texting____

Age______Date of Birth__________________________________

Emergency Contact: Name__________________________Relationship_______________Phone________________

Please note: Answers are meant to be brief. You can expand on them during your appointment. Anything you are uncomfortable writing down need not be included on this form but can be discussed in person.

Personal and Family History:

Relationship Status: Single_____ Dating_____ Married_____ Cohabitating______ Other ____________________

Pregnancies? ____

Other/Comments____

Siblings – please indicate if biological, adopted, step or half siblings :

1. Name, age,gender____
2. Name, age, gender____
3. Name, age, gender____
4. Name, age, gender____

Additional/Comments____

Who do you live with?____

Pets?____

Please indicate your major life stressors in the past 12 months or so:

Death of a family member or close friend______ Divorce/Separation______ Job Issue_______

Serious personal illness or injury_______ Major illness or injury in family_____ Gain of new family member_____

Move____ Financial____ Other____

Stressor Details____

____

Please indicate any of the following you have experienced?

Death of Mother____ Your age at occurrence_____

Death of Father____ Your age at occurrence_____

Death of Child_____ Your age at occurrence_____ Child's age_____

Death of Sibling____ Your age at occurrence_____ Siblings age____

Desertion by Mother______ Your age at occurrence_____

Desertion by Father______ Your age at occurrence_____

Divorce of Parents_______ Your age at occurrence_____

Separation of Parents_______ Your age at occurrence_____

Have you experienced: Sexual abuse____ Emotional abuse_____ Physical abuse_____

Neglect_____ Violence in the family_____ Mental illness of a family member______

Other trauma____

__Treatment Information:__

Have you ever received psychological or psychiatric counseling in the past? Yes____ No____

When?____

From Whom?____

Purpose____

Your opinion of results____

Have you ever been diagnosed with a mental health issue? Yes_____ No_____

What was the diagnosis?____

Have you ever been prescribed medication for a psychiatric or emotional concern? Yes_____ No_____

Name of medication?____

What were the results of the medication?____

Are you currently taking psychotropic medication (such as an antidepressant, anti-anxiety medication)? Yes____No____

Name and dosage of the medication____

Have you ever been hospitalized for a psychiatric or emotional health reason? Yes____ No____

Have you ever been in a drug or alcohol treatment program? Yes____ No____ Inpatient____ Outpatient____

Where?____

Outcome?____

__Medical Information__

Primary Care Physician or Clinic________________________________ Phone____________________

Date of latest physical exam___________________ Major surgeries______________________________

Chronic Illnesses____

Injuries____

Other pertinent medical____

Other Current Medications (Name, dosage, frequency)_______________________________

____

How would you describe your overall health: poor___ fair___ good____ excellent____

Do you use tobacco products?: yes___ no___ What type? cigarettes____chewing tobacco____other_____________

How much____________________________________ Use in the past?: yes____ no____

Do you use marijuana products?: yes____ no_____ How much___________Use in the past?: yes____ no____

Do you consume alcohol? yes____ no____

Frequency: Less than once a month____ once a month____ once a week____ once a day_____

Several a day_____ how many?_________________ binge drinking_____ black-outs_______________

Beer____ Wine____ Hard Liquor_____ Other info on alcohol____

Do you use any street drugs, misuse prescription drugs or use anything else to get high? Yes____ No____

Name of drug(s) and frequency____

____

Do you have any compulsive/addictive behaviors? yes___ no___

gambling______ sex______shopping_____ gaming______internet________other__________

Education background

School:____Grade: _________

Do you like school?: Yes___ No___ What is your GPA? ______

What are your plans after high school? College_____ Get a Job______ Military______ Undecided__________

Career goals____

Have you been bullied?: Yes ____ No____

Have you bullied others?: Yes ____ No ____

Employment

Do you have a job? Yes____ No_____

Current position / Job title ____Employer ________________________

Spiritual Resources

How important is spirituality in your life? Not important___ Somewhat important___ Significant___ Very significant___

Optional: Religious affiliation / faith / beliefs / denomination ____

Please describe the main concern(s) that have prompted you to seek counseling: ___________________________

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What changes would you like to make in your life? ____

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____

What are your goals for counseling? ____

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Insurance Information

Note: Clients are financially responsible for annual deductibles, co-insurance and/or co-pays not covered by insurance.

Insurance Company ____ Phone _____________________

(a copy of insurance card and personal identification required at time of first visit)

Client relationship to policy holder: Child ____ Other ____

Policy ID number _________________________________ Group number _________________________

Name of Policy Holder ____________________________Date of Birth of Policy Holder_________________

Address if different than client ____Phone________________

Employer____

Is there any other health benefit plan? Yes ___ No____

I agree to permit ***Sandy Tudor and Aquiline Counseling LLC*** *to release to my insurance company and/or their representatives any information necessary for processing my insurance claims. This information may include: personal information listed above, diagnosis, dates of office visits, types of service, and the amount of charge. My signature also indicates that the information I have provided is true and complete. I understand that failure to provide complete information will result in my being held personally responsible for all charges incurred****. I understand that I am held financially responsible for unreimbursed charges not covered by the insurance policy.***

Cash Paying Client: I understand that payment is due at the time services are rendered.

Client Signature____**Date**_____________

Parent's Signature____**Date**_____________