Aquiline Counseling
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Parental Supplement for Adolescent Client--Intake Sheet
For Adolescents 13 to 17 Years of Age

Today's Date:_____

Parent to fill out this form

Client Name; First_____ Last_____Middle Initial_____

Mother's Name: First_____Last_____Middle Initial_____

Father's Name: First_____Last_____Middle Initial_____

Address_____City_____Zip_____

Home Phone_____ Cell Phone_____Cell phone company_____

Work Phone_____Email_____

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

Home Phone____ Cell Phone____ Work Phone____ Email____ Texting____

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.

PARENTAL History (Please answer these questions about yourself):

Relationship Status: Single____ Married____ Separated____ Divorced____ Widowed____ Cohabitating____

Other_____

Length of current marriage or relationship_____ Number of divorces_____

Number of previous cohabitations_____ Other_____

Separations_____ Affairs_____

Other/Comments_____

Client's Siblings (please identify if biological, adopted, step or half):

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

Additional/Comments_____

Please indicate family's major life stressors in the past 12 months or so:

Death of a family member or close friend_____ Divorce/Separation_____ Job Issue_____

Serious illness or injury for the client_____ Major illness or injury in family_____Gain of new family member_____

Move____ Financial____ Other_____

Please indicate any of the following the client has experienced?

Death of Mother____ Age at occurrence_____

Death of Father____ Age at occurrence_____

Death of Child_____ Age at occurrence_____ Child's age_____

Death of Sibling____ Age at occurrence_____ Siblings age____

Desertion by Mother_____ Age at occurrence_____

Desertion by Father_____ Age at occurrence_____

Divorce of Parents_____ Age at occurrence_____

Separation of Parents_____ Age at occurrence_____

Has the client experienced: Sexual abuse____ Emotional abuse_____ Physical abuse_____

Neglect_____ Violence in the family_____ Mental illness of a family member_____

Other trauma_____

Treatment Information:

Has the client ever received psychological or psychiatric counseling in the past? Yes____ No____

When?_____

From Whom?_____

Purpose_____

Your opinion of results_____

Has the client ever been diagnosed with a mental health issue? Yes_____ No_____

What was the diagnosis?_____

Has the ever been prescribed medication for a psychiatric or emotional concern? Yes_____ No_____

When?_____

From Whom?_____

Name of medication?_____

Used to treat?_____

What were the results of the medication?_____

Is the client currently taking psychotropic medication (such as an antidepressant, ADHD med.)? Yes____No____

Name and dosage of the medication_____

Has the client ever been hospitalized for a psychiatric or emotional health reason? Yes____ No____

Has the client ever been in a drug or alcohol treatment program? Yes____ No____ Inpatient____ Outpatient____

Where?_____

How long?_____

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 the client's overall health: poor___ fair___ good____ excellent____

To your knowledge:

Does the client use tobacco products?: yes___ no___ What type? cigarettes____ chewing tobacco _____

other_____ Use in the past? yes_____ no_____

Does the client use marijuana products?: yes____ no_____ How much_____

Use in the past?: yes____ no____

Does the client consume alcohol? yes____ no____ Details_____

_____

Does the client use any street drugs, misuse prescription drugs or use anything else to get high? Yes____ No____

Name of drug(s) and frequency_____

_____

Family Spiritual Resources

How important is spirituality in the family's life? Not important__Somewhat important__ Significant__Very significant___

Optional:

Religious affiliation / faith / beliefs / denomination _____

_____

Describe the quality of your relationship with the client_____

_____

_____

From your perspective, why is the client seeking counseling?_____

_____

_____

_____

_____

What are your goals for the client's counseling? _____

_____

_____

_____

_____

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 ____

Client's name_____Date of birth_____

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 ***Aquiline Counseling and Training Services*** *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_____