Quarternote Counseling LLC

Parent/Guardian Section of Adolescent Intake

Date form filled out:

Name of Adolescent:

Date of Birth of Adolescent:

Name of Parent/Guardian:

Relationship to Adolescent:

What caused you to conclude that the individual would benefit from counseling?

How have the individual's challenges impacted you/family?

Individual's Primary Medical Provider Name and Contact Number

How would you describe the individual's current health status (poor, unsatisfactory, satisfactory, good, very good, excellent)?

Are they adopted?

Are you aware of any problems the biological mother experienced while pregnant with the individual or in giving birth?

Was the individual born prematurely?

As far as you know, did they walk/talk/toilet-train at the expected ages?

At what age did they start school?

Do you believe they have any learning disability?

Did their parents divorce/separate?

If, yes, what age were they at the time?

Did the parents ever re-marry?

Does the individual have siblings?

If yes, how many and what are their ages?

Past Medical History (major illnesses or surgeries)

Mental Health History, including any previous psychotherapy.

Medications (prescription, supplements, herbals, psychiatric medications, please list.)

Has the individual ever been prescribed psychiatric medication?

Allergies to medications, environmental, insects

Self Harm

History of suicidal thoughts or attempts

History of self injurious behavior

Conflict with Family?

Peer Relations ?

History of Running Away?

Domestic Violence or abuse neglect problems exposure?

Fire setting?

Cruelty to animals?

Bullying or being bullied?

Bed wetting/soiling?

School problems?

Parental Drug and/or alcohol use/abuse ?

Has the adolescent experienced a trauma (something the individual found very upsetting) at any point, including in infancy and early childhood?

What is your goal for therapy for the individual?

Parent/guardian signature____

Therapist signature indicating document reviewed ____