BAYSIDE THERAPY ASSOCIATES TEEN INTAKE FORM

INSTRUCTIONS: PLEASE COMPLETELY FILL OUT BOTH SIDES.

Date: ______________________ Form filled out by: Self Other: ______________________
Client Name: ____________________________ Date of Birth: ______________ Age: ________
Gender: Female Male ______________ Social Security #: _______________________
Referred By: _______________________ Primary Care Doctor: ____________________________

Address: ____________________________________ City/State/Zip: ________________________
Home Phone #: ________________ Cell #: ________________ Work Phone #: _______________
OK to leave message? **YES NO** **YES NO** **YES NO**

Parent/Guardian Name: ___________________________Date of Birth: ___________ SSI#: _________________
Address (if different than above): ________________________________ City/State/Zip: __________________________
Phone # (If different than above): ____________ Cell: ____________ Okay To Leave Messages At These Numbers: **Yes** **No**
Mothers Employer: ______________________ Address: ________________________ Phone#: ______________
Parent/Guardian Name: ____________________________ Date of Birth: ___________ SSI #: _______________
Address (if different that above): ________________________________ City/State/Zip: __________________________
Phone # (if different than above): _____________ Cell: _____________Okay To Leave Messages At These Numbers: **Yes** **No**
Fathers Employer: _______________________Address: _________________________ Phone#:_____________

Person Responsible for Account: ____

PRIMARY INSURANCE

No Insurance Coverage
Insurance Co.: __________________________
Insurance Co. Address: __________________
____
Insurance Co. Phone #: __________________
Client ID#: ____________________________
Group/Plan #: ___________________________
Policy Holder Name:_____________________
Date of Birth:_________ SS #:_____________
Relationship to you: _____________________

SECONDARY INSURANCE

Insurance Co.: __________________________
Insurance Co. Address: __________________
____
Insurance Co. Phone #: __________________
Client ID#: ____________________________
Group/Plan #: ___________________________
Policy Holder Name:_____________________
Date of Birth:_________ SS #:_____________
Relationship to you: _____________________

FOR OFFICE USE ONLY

Dates of Referral: _______________ to ______________Date First Consulted: _______________
Number of Sessions: _____________ Ded.: ____________Co-pay/Co-ins: ____________________

Date	dx code	dx	Counselor Signature

Developmental History: (check all that apply for adolescent client)

Any problems during or after mother's pregnancy?

None
Emotional Stress
Alcohol Use
Drug Use

Cigarette Use
Domestic Violence
Postpartum Depression

Other: ______________________
____
____

Birth: Normal Delivery Difficult Delivery Cesarean Delivery Complications: ___________________________
____ Birth Weight: _____lbs. ____ oz.

Infancy: Feeding Problems Sleep Problems Toilet Training Problems Attachment Problems

Delayed Developmental Milestones: (check all that apply)

Sitting
Rolling Over
Crawling
Standing
Walking

Feeding Self
Speaking Words
Speaking Sentences
Controlling Bladder
Controlling Bowels

Dressing Self
Engaging Peers
Tolerating Separation
Playing
Riding Bicycle

Childhood Health: (check all that apply)

Visual Problems
Hearing Problems
Problems with Coordination
Physical, Sexual or Emotional Abuse
Weight Loss/Gain
Speech Problems

Ear Infections
Headaches
Nausea/Vomiting
Lead Poisoning
Seizures
Soiling/Bedwetting
Head Injury

Broken Bones
Asthma
Stomach Aches
Allergies to: __________
____

Any chronic or serious health problems: ____

MEDICAL HISTORY

Describe Current Physical Health: **Good** **Fair** **Poor**

List all medications teen is taking. Include non-prescription drugs and health supplements.

Drug Name:	Date Began:	Purpose:	Dosage:	# Per Day:
1.				
2.				
3.				

Prescribed By: ____

Do you have any allergies to medication? Yes No If yes, which ones? ______________________________________

Describe Any Hospitalization, Surgeries or Accidents

Date: __________________ Age: __________ Reason: ____
Date: __________________ Age: __________ Reason: ____
Date: __________________ Age: __________ Reason: ____

SUBSTANCE USE

Check past or current substance use:							
	Past Use	Current Use	How Often		Past Use	Current Use	How Often
Hard Liquor				Tranquilizers/Sleeping Pills			
Beer/Wine				Inhalants			
Marijuana				Cocaine			
Speed/Amphetamine				Nicotine			
Heroin/Painkillers				Coffee			
Hallucinogens/Ecstasy				Soft Drinks			
PCP				Other			

Consequences of Substance Abuse: (check all that apply):

Hangovers
Seizures
Blackouts
Overdose
Withdrawal Symptoms
Medical Conditions
Changes
Loss of Control Amount Used
Sleep Disturbance
Assaults
Suicidal Impulse
Relationship Conflicts
Binges
Interference with School
Job Loss
Arrests

Check any of the conditions your teen has had and the date of onset:					
Condition	**Date**	**Condition**	**Date**	**Condition**	**Date**
ADD/ADHD		Behavior Problems		Learning Disability	
AIDS/HIV		Bipolar Disorder		Low Blood Pressure	
Allergies		Cancer		Migraines	
Anemia		Cutting		Obesity	
Anger Problems		Diabeties		Obsessive/Compulsive	
Anxiety		Eating Disorders		Panic Attacks	
Arthritis		Epilesy.Siezure Disorder		Stomach Ulcers	
Asthma		Head Trauma		Skin Problems	
Autism		Heart Disease		Suicide Attempts	
Aspergers		High Blood Pressure		Thyroid Disease	
Depression		Hypoglycemia		Other:	

Check any of the following you have had in the past three months:

Vision Problems
Stomach Aches
Memory Loss
Dizziness
Shortness of Breath
Back Pain
Head Injury
Weakness in Arms or Legs
Constipation
Loss of Consciousness
Chest Pains or Tightness
Hearing Loss
Convulsion/Seizures
Diarrhea
Chronic Pain
Fainting
Nausea or Vomiting
Unusual Bleeding
Menstrual Irregularities
Headaches
Abnormal Growth or Lump

Psychiatric History:

Prior **Out**patient Therapy? Yes No Provider Name: ___________________________ Was It Beneficial?: Yes No

Prior **In**patient Therapy? Yes No Facility Name: ____________________________ Was It Beneficial?: Yes No

Is there a history of any of the following in your family:											
	GRAND-PARENT	PARENT	SIBLING		GRAND-PARENT	PARENT	SIBLING		GRAND-PARENT	PARENT	SIBLING
ADD/ADHD				Birth Defects				Obsessive/Compulsive			
Alcoholism				Cancer				Panic Disorder			
Alzheimer's Disease/Dementia				Depression				Schizophrenia			
Anger Problems				Diabetes				Seizure Disorder			
Anxiety Disorder				Drug Abuse				Suicide/Homicide			
Aspergers/Autism Disorder				Heart Disease				Thyroid Problem			
Behavior Problems				High Blood Pressure				Violent/Abusive Behavior			
Bipolar Disorder				Mental Retardation				Other:			

Academic Functioning: (check all that apply)

Learning problems
Difficulties with homework
Attention problems
Difficulties with schoolwork
Authority conflicts
Underachieving

Current or Highest Education Level: _______________ **School**: ____

Cultural/Spiritual (e.g., ethnicity, religion): ____

Family of Origin

	Present Entire Childhood	Present Part of Childhood	Not Present At All	Current Age
Mother				
Father				
Stepmother				
Stepfather				
Brother(s)				
Sister(s)				
Other (specify)				
Stepbrother(s)				
Stepsister (s)				

Parents Current Marital Status:

Married to Each Other
Separated for _______ Years
Divorced for ________ Years
Mother Remarried ________ Times
Father Remarried __________Times
Mother Involved with Someone
Father Involved with Someone
Mother Deceased For ______Years
Father Deceased For _______ Years

List other person living in teen's home:		
Name:	Age:	Relationship to Teen:

LIST OF CHILDREN BEHAVIORS: Please use the following scale to rate your child on each behavior. Indicate how often your child displays that behavior by circling the number which best describes the frequency of each behavior.

1	2	3	4	5
Never	**Rarely**	**Occasionally**	**Frequently**	**Very Frequently**

GROUP A

1	2	3	4	5	Has trouble sleeping
1	2	3	4	5	Has poor appetite
1	2	3	4	5	Seems sad or unhappy
1	2	3	4	5	Talks about feeling stupid or worthless
1	2	3	4	5	Loses interest in having fun
1	2	3	4	5	Seems irritable
1	2	3	4	5	Moody
1	2	3	4	5	Plays alone
1	2	3	4	5	Cries easily
1	2	3	4	5	Seems tired

GROUP B

1	2	3	4	5	Complains about physical problems: like headaches or stomachaches
1	2	3	4	5	Worries
1	2	3	4	5	Lacks confidence in their abilities
1	2	3	4	5	Needs lots of reassurance
1	2	3	4	5	Needs to be perfect
1	2	3	4	5	Seems fearful and anxious
1	2	3	4	5	Seems shy or timid
1	2	3	4	5	Easily embarrassed
1	2	3	4	5	Sensitive to criticism
1	2	3	4	5	Bites fingernails

GROUP C

1	2	3	4	5	Always on the go
1	2	3	4	5	Can’t sit still
1	2	3	4	5	Doesn’t seem to listen
1	2	3	4	5	Often fails to finish things
1	2	3	4	5	Has poor concentration and attention when comes to schoolwork
1	2	3	4	5	Often fidgets with hands/feet or squirms in seat
1	2	3	4	5	Easily distracted
1	2	3	4	5	Has a hard time playing quietly
1	2	3	4	5	Talks excessively
1	2	3	4	5	Often interrupts or “butts in” to others’ games
1	2	3	4	5	Seems disorganized, loses things they need for school
1	2	3	4	5	Takes risks without considering the danger involved (e.g. running into the street without looking)
1	2	3	4	5	Blurts out answers to questions before they have been completed

GROUP D

1	2	3	4	5	Refuses to follow directions or do chores
1	2	3	4	5	Loses temper
1	2	3	4	5	Argues with parents or teachers
1	2	3	4	5	Blames others for their mistakes
1	2	3	4	5	Swears
1	2	3	4	5	Deliberately does things to annoy other people
1	2	3	4	5	Is angry or resentful
1	2	3	4	5	Carries a grudge, seems to have “a chip on their shoulder”
1	2	3	4	5	Touchy, easily annoyed by others

GROUP E

1	2	3	4	5	Steals
1	2	3	4	5	Runs away overnight
1	2	3	4	5	Lies
1	2	3	4	5	Skips school
1	2	3	4	5	Is cruel to animals
1	2	3	4	5	Destroys property
1	2	3	4	5	Gets into fights
1	2	3	4	5	Has been physically cruel to people
1	2	3	4	5	Doesn’t seem sorry for hurting others
1	2	3	4	5	Sets fires
1	2	3	4	5	Has broken into someone a house or car

GROUP F

1	2	3	4	5	Compulsive behavior
1	2	3	4	5	Alcohol or drug use
1	2	3	4	5	Lack of attachment
1	2	3	4	5	Separation problems
1	2	3	4	5	Self-injury acts
1	2	3	4	5	Self-injury threats
1	2	3	4	5	Indecisive
1	2	3	4	5	Immature
1	2	3	4	5	Odd behavior
1	2	3	4	5	Upset with physical appearance
1	2	3	4	5	Sexual behavior
1	2	3	4	5	Distrustful
1	2	3	4	5	Concerns regarding peer influence
1	2	3	4	5	Teased or bullied
1	2	3	4	5	Watches television
1	2	3	4	5	Plays video games
1	2	3	4	5	Internet use

Form Completed By: ____ **Date:** ______________________

General Information:

Has your teen experienced any serious upsets? YES NO If yes, what kind: ____________________
____

Has your teen suffered any significant losses? YES NO If yes, please explain: ________________
____

Does your teen have any particular fears? YES NO Comments? ___________________________
____

Any problems with sleeping? YES NO Comments? ______________________________________
____

Any problems with discipline? YES NO If yes, please describe:____________________________
____

How active is your teen? ____
____

List your teen's strengths: ____
____
____

Please add any information you feel would be helpful: _____________________________________
____
____

TREATMENT GOALS:

Please list issues to discuss in therapy and specific goals you wish to accomplish:

____
____
____
____
____
____
____