Counseling with Sara, LLC

Confidential Counseling Intake Form for Minors ages 14-17

The information on this form will help your counselor know more about you as you begin counseling.

Today's date _____ Name _____ Gender _____

Preferred Name _____ Date & Place of Birth _____

Address _____ Phone _____

OK to send mail? Yes No * OK to leave phone messages? Yes No * OK to text? Yes No

**Please note: texting and email are used for administrative purposes only (i.e. appointment scheduling).*

School you attend and location _____ Grade_____

Do you have an IEP (Individual Education Plan)? Yes No Unsure

Who has legal custody of you? _____

Is there anything you want to share about your culture? _____

_____

Do you have any disabilities you want to share with me? _____

Has a member of your family served in the military? _____

Person to contact in case of emergency _____

Phone _____ Relationship to you _____

How did you hear about counseling services with me? _____

Family Summary

First names of people living with you	Age	Relationship to you	Significant information?

Do you have other family members not living with you? _____

What has it been like for you growing up in your family? _____

_____

Health Summary

Describe any important medical information _____

_____

Do you take any medications? Please list _____

Name of Primary Care Doctor _____ Date of last doctor's visit _____

How would you rate the following about yourself (circle):

Current Physical Health	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Eating Habits	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Exercise Habits	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Sleep Habits	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Peace vs. Worry	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Calmness vs. Tension	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Hopefulness	Very Good	Good	Satisfactory	Unsatisfactory	Poor
Social Support System	Very Good	Good	Satisfactory	Unsatisfactory	Poor

Does anyone in your family and/or in your current living situation have a history of addiction or is currently using alcohol, drugs, or other addictive behaviors? *Yes* *No* If Yes, please describe below:

_____

Substance Use (circle):

Caffeine	Seldom	Often	Daily	Never	Past Use	Amount _____
Nicotine	Seldom	Often	Daily	Never	Past Use	Amount _____
Alcohol	Seldom	Often	Daily	Never	Past Use	Amount _____
Marijuana	Seldom	Often	Daily	Never	Past Use	Amount _____
Opiates (pain pills, heroin)	Seldom	Often	Daily	Never	Past Use	Amount _____
Sedatives (benzos, sleeping pills)	Seldom	Often	Daily	Never	Past Use	Amount _____
Cocaine/Crack	Seldom	Often	Daily	Never	Past Use	Amount _____
Methamphetamine	Seldom	Often	Daily	Never	Past Use	Amount _____
Other Stimulants (speed, uppers)	Seldom	Often	Daily	Never	Past Use	Amount _____
Hallucinogens (PCP, mushrooms)	Seldom	Often	Daily	Never	Past Use	Amount _____
_____ (other)	Seldom	Often	Daily	Never	Past Use	Amount _____

Do you have any concerns about addiction to substances, behaviors, and/or other activities? *Yes* *No* *Not Sure*

Have you ever attended a treatment program? *Yes* *No* If Yes, _____

Have you or anyone in your family had concerns with depression, anxiety, suicide, and/or mental illness? Yes No

If Yes, please describe _____

Have you ever been diagnosed with a mental health condition? *Yes* *No* *Unsure* If Yes, please describe below:

_____

In your opinion, do you need to be here? *Yes* *No* *Unsure*

Do you want to be here for counseling? *Yes* *No* *Unsure*

Have you ever been in counseling before? *Yes* *No* If Yes, was it helpful? *Yes* *No* *Somewhat* When? _____

Have you ever attempted suicide? *Yes* *No* Have you ever experienced suicidal thoughts? *Yes* *No*

Have you ever participated in self-harming behaviors (i.e. cutting)? *Yes* *No* *Current* *Past*

Are you currently experiencing suicidal thoughts? *Yes* *No*

Do you have current suicidal plans, intentions, behaviors? *Yes* *No*

Are you currently experiencing any violent or homicidal thoughts? *Yes* *No*

Please feel free to include any other information you think is important here _____

_____

What would you like help with in counseling? _____

_____

_____

How long has this been troubling you? _____ How bad is it? Mild Moderate Serious Severe

What else is related to this issue(s)? (Please mark all that apply and circle any specifics in a list of items)

- ☐ Abuse: Physical, Sexual, Emotional, Physical
- ☐ Anger, Irritability
- ☐ Anxiety, Worry
- ☐ Behavior Issues
- ☐ Body Image
- ☐ Childhood Issues (your childhood)
- ☐ Depressed Mood, Sadness, Crying
- ☐ Divorce, Separation of Parents
- ☐ Eating, Weight Management, Eating Disorders
- ☐ Emotions, Mood Swings
- ☐ Family Difficulties
- ☐ Fatigue, Tiredness, No Energy
- ☐ Fears or Panic
- ☐ Forgiveness, Resentment Issues
- ☐ Friendship Difficulties
- ☐ Future: Career Concerns, Goals, College, Plans
- ☐ Gender Identity
- ☐ Grief, Loss, Death, Mourning
- ☐ Guilt, Shame
- ☐ Hearing Voices
- ☐ Hopelessness
- ☐ Loneliness, Isolation
- ☐ Nervousness, Tension
- ☐ Obsessions, Compulsions, Perfectionism
- ☐ Physical Health, Pain
- ☐ Pornography Concerns
- ☐ Pregnancy and/or Abortion
- ☐ Racing Thoughts
- ☐ Recurring or Intrusive Thoughts
- ☐ School/Academic Concerns
- ☐ Seeing Things That Others Don't
- ☐ Self-Esteem, Self-Concept
- ☐ Sexual Concerns
- ☐ Sexual Identity (Gay, Bisexual, Questioning)
- ☐ Shyness
- ☐ Sleep Problems
- ☐ Social Anxiety
- ☐ Spiritual/Faith Concerns
- ☐ Substance Use, Alcohol, Drugs
- ☐ Suicidal Thoughts, Feelings
- ☐ Support System
- ☐ Unable to Have Fun
- ☐ Unwanted Sexual Contact as a Child or Teen
- ☐ Work
- ☐ Other: _____

Other Helpful Information for Counseling

Do you have a religious faith or spiritual practices? _____

_____

Do you want to include aspects of your spirituality (if any) into counseling? *Yes* *No* *Unsure*

How would you like things to be different after you have completed counseling?_____

_____

Who in your life do you count on for support? _____

What brings you the most joy in your life? _____

What are your main worries and fears? _____

What are your most important hopes and dreams? _____

How do you feel about who you are and the ways you have developed as a person? _____

_____

What do you most like about yourself? _____

What are some of your strengths that you bring with you to counseling? _____

_____

I have done my best to answer these questions as honestly and completely as possible.

_____ _____

Client Signature Date

Thank you for taking the time to fill out this form.