Adolescent Intake Information
(To be completed by parents/guardians)

Part 1: Basic Demographic Information

Name of Adolescent:_____
Last First Middle

Gender: _____ Age: _____ Date of Birth: _____/_____/_____

Address:_____

_____

E-mail: _____

Phone number: _____

Emergency Contact, Relationship, and phone number:_____

_____

Part 2: Family Life

1. Name of Parent/Guardian:	Relationship to Child:
Home address:	Date of Birth:
Occupation:	Home Phone:
Employer:	Cell Phone:
2. Name of Parent/Guardian	Relationship to Child:
Home address:	Date of Birth:
Occupation:	Home Phone:
Employer:	Cell Phone:

What is the relationship status of the parents/guardians? _____

With whom does the child live? _____

Who has legal custody? _____

Who is responsible for payment? _____

Please list all other immediate family members and/or people living in the house

Name	Age	Relationship

Part 3: Financial Information

What method of payment will be used? (Initial as indicated)

_____ I am paying out-of-pocket

_____I am using health insurance benefits

Health Insurance Company: _____

Name of Policy Holder: _____

Policy Holder D.O.B.: _____Relationship to client: _____

Insurance ID #: _____Group #: _____

Initial below as indicated:

_____: If self-paying:
I understand I am financially responsible for all services, charges, and fees

_____: If using insurance benefits:
I hereby authorize my insurance benefits to be paid directly to Cynthia Stanford, LMFT for services rendered. I authorize the release of any information as required by my insurance company or other reimbursing agency. I understand I am financially responsible for the charges not covered by my insurance company.

Some find it convenient to put a credit card on file. This can be helpful when adolescents attend appointments alone, or when clients have busy schedules or late appointment times. If you prefer to use a different payment method **you are not required to provide this information.**

Cardholder Name: _____

Visa/Mastercard (please circle) Number: _____

Expiration: _____V-code: _____ Billing zip code: _____

_____ I authorize my credit card to be billed by Cynthia Stanford, LMFT, for all copays, fees, and services rendered that are not covered by my insurance company (please initial)

_____ _____

Signature of parent/guardian Date

Part 4: Parent/Guardian Questionnaire for Adolescent Intake

I. Initial Thoughts

Name of person completing survey: _____

Briefly describe your reason for seeking counseling for your child: _____

_____

_____

What are your goals/hopes for your child's treatment? _____

_____

_____

II. Demographics

Ethnicity: _____

Native Language: _____

Gender Identity: _____

Sexual Orientation: _____

Religious/Spiritual Affiliation: _____

Is your child adopted? ☐ yes ☐ no If yes, at what age? _____

Does your family have any financial concerns? ☐ yes ☐ no If yes, describe: _____

_____

Are there any past or present legal issues in the family? ☐ current ☐ past ☐ never

Describe: _____

_____

III. Mental Health Treatment History

If applicable, please list your child's mental health treatment history in the following table

Treatment Type	Treatment Provider(s)	Issues Addressed	Dates
Outpatient Counseling			
Psychiatry			
Hospitalizations (for mental health reasons)			
Partial Hospitalization (PHP) or Intensive Outpatient (IOP)			
Drug/Alcohol Rehabilitation			
Residential Therapeutic Program			
Other			

Is your child currently prescribed any psychoactive medications? ☐ yes ☐ no

If yes, please complete the chart on the following page

Medication	Dose	Start Date	Condition Treated
1)			
2)			
3)			
4)			

Has your child recently discontinued any psychoactive medications? ☐ yes ☐ no

If yes, please describe: _____

Is there any family history of mental health issues, including drug or alcohol dependency? Include parents, siblings, grandparents, aunts, uncles, and cousins:

_____

_____

Are you worried about any potential drug and/or alcohol abuse? Please describe: _____

_____

_____

Additional Comments regarding mental health history: _____

_____

IV. Physical Health

How would you describe your child's physical health? ☐ Poor ☐ Below Average ☐ Average ☐ Above Average ☐ Excellent

List any current medical conditions or concerns: _____

_____

_____

Allergies: _____

Do you have any concerns with your child's nutritional or exercise habits? ☐ yes ☐ no

Describe: _____

_____

Were there any problems during pregnancy or delivery? _____

_____

Were developmental milestones met on time?_____

_____

Is there any other medical information you feel is important? _____

_____

V. Educational History

Current School: _____ Current Grade: _____

Does your child receive special education services? Have a 504 plan or IEP? Ever repeated a

grade? Please describe: _____

_____

Please describe any concerns related to academics: _____

_____

_____

VI. Psychosocial Information:

Do you think your child has experienced any events as traumatic (e.g. death of a loved one, a difficult transition, separation or divorce, peer ridicule, etc)? ☐ yes ☐ no

Please describe: _____

_____

_____

Do you have social concerns for your child? ☐ yes ☐ no If yes, describe: _____

_____

_____

What do you see as your child's biggest strengths and positive qualities? _____

_____

_____

Is there any other information you would like me to know at this time?_____

_____

_____