

Adolescent Intake Parent(s)

PARENT/GUARDIAN INFORMATION		
Name:	Date:	
Home Address:	City, State, Zip:	
Preferred Phone:		
Email Address:		
May we leave messages on your preferred phone? Yes No		
May we send mail to this address? Yes No		
FAMILY INFORMATION		
Marital Status: Married Single Divorced Widow	ved Cohabitating	
Date of Current marriage/divorce/cohabitation:	Number of Marriages:	
Previously Married: Yes No If yes, when?	How Long:	
Spouse/partner's name:	_ DOB:	
Child(ren)'s Names:	DOB:	M F
	DOB:	M F
	DOB:	M F
	DOB:	M F
Occupation:	_ Highest Level of	Education:
Name of other Custodial Parent:	Cell Phone:	
Do you have consent from the other Custodial Parent for treatment of	said child? Yes	No
If no, this will be required by therapist before counseling can begin.		
How much contact per month does the child have with his biological m	other/father?	
SPIRITUALITY		
Do you believe in God or a Higher power? Yes No		
What is your religious preference?		
Are you a member of a Spiritual/Religious comminity?		
If yes, what Spiritual/Religious community?		
How much influence does your Sprituality have on a daily basis?	Significant Modera	te Some None
Complete all remaining information according	g to the child coming in	n for treatment
GENERAL INFORMATION		
Name:	DOB:	M F
The child is currently living with:		
School:	Grade:	
Extracurricular activities & interests:		
MEDICAL HISTORY		
How would you rate your child's current physical health? [Excellent Good	Fair Poor

Is the child currently complaining of any physical problems such as headaches or stomach aches? ___ Yes ___ No

If yes. please explain:				
Previous hospitalizations for medical reasons:	Date:	Reason:		
	Date:	Reason:		
Please list any medical conditions or disabilities: _				
Please list any learning differences:				
MEDICATIONS (including Psychiat	tric)			
Over-the-Counter & Prescription		Dosage		
COUNSELING AND PSYCHIATRIC HISTORY				
Has the child had previous counseling? Yes	No If yes, w	when? For how long?		
For what reason?				
Name and location of counselor:				
Has the child ever been diagnosed with or treated	I for any type of m	ental illness? Yes No		
If yes, which type?				
Has anyone in the child's family ever been diagno	sed with or treated	d for any type of mental illness? Yes No		
If yes, which type?				
REASONS FOR SEEKING HELP				
What concerns about the child have brought you	to counseling today	y?		
Where are these concerns causing the most probl	ems for YOU? Plea	se check all that apply:		
Home Work	Marriage	Other		
When are these concerns causing the most proble	ems for the CHILD?	Please check all that apply:		
Home School	Friends (Other		
When did the present concerns become a problem	n for the child?			
What concerns about the child have been identified	ed by others?			
Please indicate which of the following areas are cu	urrently a problem	for the child. Check all that apply:		
Crying Spells	Crying Spells Hyperactivity			
Excessive fears or anxieties		Bullying or picking fights		
Difficulty being away from specific far	nily members	Refusal to respond to authority		
Hearing voices		Nightmares		
Getting into trouble at school/play		Obsessions/compulsions with specific activities		
Temper tantrums		Lack of motivation		
Difficulty falling asleep/inability to sle	ep at night	Lack of self confidence		
Decreased/increased appetite		Difficulty making or keeping friends		
Loss of interest in usual activities		Other:		
What do you hope to gain from counseling?				
How did you hear about Auxano Counseling?				