



## Adolescent Intake Parent(s)

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### 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

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### FAMILY INFORMATION

Marital Status:  Married  Single  Divorced  Widowed  Cohabiting  
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 mother/father? \_\_\_\_\_

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### 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 community? \_\_\_\_\_  
If yes, what Spiritual/Religious community? \_\_\_\_\_  
How much influence does your Sprituality have on a daily basis?  Significant  Moderate  Some  None

**Complete all remaining information according to the child coming in for treatment**

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### GENERAL INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M F  
The child is currently living with: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Extracurricular activities & interests: \_\_\_\_\_

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### 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

