Client Name: _____

**Lake Orion Counseling Center, P.C.**
**Intake – Children & Adolescents**

Name: _____ Preferred Name: _____
Birth Date: _____ Age: _____ Gender: Male ____ Female _____ Unsure _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone (Home): _____ Work: _____ Cell: _____
Email: _____
Height: _____ Weight: _____ Does your weight fluctuate? Yes ___ No _____
If yes, by how much? _____ Do you have Problems with Eating? Yes ____ No ____
Do you struggle with self image? Yes _____ No _____
Do you have a family physician? Yes ____ No ____
Name of physician: _____ Phone number: _____
How were you referred here? _____
Responsible Party: _____ Relationship: _____
Emergency Contact: _____ Telephone: _____
Please indicate the primary reason for seeking therapy and what you hope to accomplish through therapy:_____

_____

Please estimate the severity of your problem:
_____ Mildly upsetting ___Moderately upsetting ___ Severely upsetting ___ Totally incapacitating

**Past Mental Health Experiences/Current Assessment of Risk to Self:**

Have you been in therapy for mental health problems in the past? Yes _____No _____
If yes, please explain (provide details including where/when/results/medications): _____

_____

_____

Have you ever been hospitalized for psychological/psychiatric problems? Yes ____ No _____
If yes, when/where? _____
_____

_____

Have you ever attempted suicide? Yes ____ No _____
Current thoughts of suicide? Yes ____ No ____ Do you have a plan? Yes ____ No ____
Has any relative attempted or committed suicide? Yes ____ No ____
Have you ever done things to injure yourself not intending suicide? Yes ____ No ____
If yes to any of the above, please describe:
_____
_____
_____

Client Name: _____

**Family History**

Place of Birth: _____ Where you mostly grew up:_____

Ages for times you moved: _____

Father: Name: _____ DOB: _____

Email address: _____ Phone:_____

Occupation:_____ Education:_____ Health:_____

If deceased, give his age at time of death:_____ How old were you at the time:_____

Cause of death:_____

Please describe your relationship with your father: _____

_____

_____

Mother: Name:_____ DOB:_____

Email address: _____ Phone: _____

Occupation:_____ Education:_____ Health:_____

If deceased, give her age at time of death: _____ How old were you at the time:_____

Cause of death:_____

Please describe your relationship with your mother: _____

_____

_____

Describe parent's relationship with each other: _____

_____

Stepparent History (i.e. your age when each parent remarried): _____

_____

Please describe your relationship with any stepparents: _____

_____

With whom do you live while growing up? _____

If not with parents, please explain: _____

# of Siblings: _____ Your Birth Order: _____

Names and ages of siblings: _____

_____

_____

Describe your overall relationships with your siblings:

_____

_____

_____

Client Name: _____

For any deceased Brothers and Sisters:

Name: _____ Cause of Death _____ Age at Death _____

Name: _____ Cause of Death _____ Age at Death _____

In what ways are you disciplined or punished by your parents? _____

_____

_____

Is the discipline/punishment fair and effective? Yes _____ No ____

Are you able to confide in your parents? Yes _____ No _____

Do you have difficulties asking them for help? Yes _____ No _____

Check any of the following that occurred during your childhood/adolescence:

| | | |
|---|---|---|
| ___ Happy Childhood | _____ Not many friends | _____ Sexually abused |
| ___ Unhappy Childhood | _____ School problems | _____ Severely bullied or teased |
| ___ Eating disorder | _____ Medical problems | _____ Emotional/behavior problems |
| ___ Legal trouble | _____ Financial difficulties | _____ Strong religious beliefs |
| ___ Death in the family | _____ Feeling ignored | _____ Severely punished |
| ___ Used alcohol | _____ Drug use | _____ Parental drug/alcohol abuse |

___ Other: _____

_____

**Education**

Current School: _____ Current grade: _____

Do you enjoy school? Yes _____ No _____

If no, please explain: _____

_____

What other schools have you attended? _____

_____

Are there any problems in your relationships at school? Yes _____ No _____

If yes, please describe: _____

_____

_____

Overall attitude and experience with school: _____

_____

Parent's attitude/involvement with education: _____

_____

Prior experience with special education classes or special considerations? Yes _____ No _____

If yes, please explain: _____

Biggest Difficulties in School? _____

_____

Client Name: _____

How do you deal with it? _____

_____

Biggest area of strength in school: _____

_____

**Interpersonal Relationships:**

Do you make friends easily? Yes _____ No _____ Do you keep them? Yes ____No _____

What are activities you enjoy doing with friends? _____

_____

Describe any relationship that gives you:

Joy: _____

_____

Anger: _____

_____

Anxiety: _____

_____

Please rate your level of comfort in social situations:

Very relaxed 1 2 3 4 5 6 7 Very anxious

Are you able to ask friends for help? Yes ___ No _____

Do you rate your friendships as satisfying? Yes ____ No_____

**Leisure Time**

How do you spend most of your leisure time? _____Alone _____With others _____ About Equal

List your hobbies, leisure time activities, interests and talents: _____

_____

_____

Have your leisure activities changed recently? Yes _____ No _____

If yes, explain how: _____

_____

Please estimate how much time per week you spend on Social Media _____ Video Games _____

Are there problems related to the amount of time you spend on these areas? Yes ____ No ____

If yes, please explain _____

_____

**Legal Problems**

Have you ever been involved with the police or the courts? Yes _____No _____

If yes, briefly describe the charges and outcomes: _____

_____

_____

Are you currently on probation? Yes ____ No _____

If yes, please explain: _____

Client Name: _____

**Spiritual Assessment**

Do you attend religious services with your family? Yes _____ No _____
Is religion a positive influence on you? Yes _____ No _____
Please list your cultural and ethnic background: _____
_____

**Please complete the following:**

One of the ways people hurt me is: _____
_____
My best friend thinks I am: _____
_____
People dislike me when: _____
_____
When I am upset I am most likely to respond by: _____
_____

**Biological Information**

Was the pregnancy full term? Yes _____ No _____ Any complications? Yes _____ No _____
How was your mother's health during and after the pregnancy? _____
Were developmental milestones met on time? Yes _____ No _____ If no, please explain delays: _____
_____
Do you have any concerns about your current physical health? Yes _____ No _____
If yes, please explain: _____
_____
_____
Please list any significant medical problems that apply to you or members of your family: _____
_____
_____
Please list any surgeries and dates: _____
_____
Please list any physical handicaps: _____
_____
Are you satisfied with your appearance and abilities? Yes _____ No _____
If no, please explain: _____
_____
_____

Have you been diagnosed with (check all that applies)?

| | | | | | |
|---|---|---|---|---|---|
| | Heart Disease | | Pituitary Gland Disorder | | Sugar Diabetes |
| | Cancer | | Pneumonia | | Allergies |
| | Ulcers | | Gastro Intestinal Disorder | | Thyroid Condition |
| | Asthma | | High or Low Blood Pressure | | Sexual Transmittable Disease |
| | Hypoglycemia | | Pre Menstrual Syndrome | | Convulsions or Seizures |
| | Colitis | | Tested Positive for H.I.V. | | Abnormal/Painful Menstruation |
| | Infertility | | Miscarriages | | Other: |

Please list any medications you are taking: _____
_____

Client Name: _____

Do you eat three balanced meals each day? Yes _____ No _____
Do you have any difficulties sleeping? Yes _____ No _____ Amount of sleep each night? _____Hours
Do you get regular physical exercise? _____ Yes _____ No
Any family history of physical or emotion difficulties or struggles with addiction? Yes_____ No _____
If yes, please describe: _____
_____
_____
Have you had any experience with addiction and treatment? Yes _____ No _____
If yes, please detail: _____
_____
_____
Do you currently use alcohol or drugs? Yes _____ No _____
If yes, please describe the type, amount and frequency:
_____
_____
Do you currently smoke cigarettes or drink caffeine products? Yes _____ No _____
If yes, how much/how often? _____

**Females (menstrual history)**
Age at first period: _____ Were you informed? Yes _____ No ___ Did it come as a shock? Yes __ No ___
Are your periods regular? Yes_____ No_____ Duration:_____
Do you have pain Yes __ No ___
Do your periods affect your moods? Yes _____ No _____
Do your periods affect your relationships with others? Yes _____ No _____

**Trauma experience**
Any history of trauma or significant loss? Yes _____ No _____
If yes, please describe: _____
_____
_____
_____
_____

_____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date Relationship to client

I have reviewed this questionnaire with the patient/informant: _____
Clinician's Signature/Credentials Date
(Coordinator of services)