

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Happy Childhood     | <input type="checkbox"/> Not many friends       | <input type="checkbox"/> Sexually abused             |
| <input type="checkbox"/> Unhappy Childhood   | <input type="checkbox"/> School problems        | <input type="checkbox"/> Severely bullied or teased  |
| <input type="checkbox"/> Eating disorder     | <input type="checkbox"/> Medical problems       | <input type="checkbox"/> Emotional/behavior problems |
| <input type="checkbox"/> Legal trouble       | <input type="checkbox"/> Financial difficulties | <input type="checkbox"/> Strong religious beliefs    |
| <input type="checkbox"/> Death in the family | <input type="checkbox"/> Feeling ignored        | <input type="checkbox"/> Severely punished           |
| <input type="checkbox"/> Used alcohol        | <input type="checkbox"/> Drug use               | <input type="checkbox"/> Parental drug/alcohol abuse |
| <input type="checkbox"/> 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? \_\_\_\_\_

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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: \_\_\_\_\_

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**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)?

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

Please list any medications you are taking: \_\_\_\_\_

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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  
(Coordinator of services)

Date