



## Adolescent Intake

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Who are you presently living with? \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Job: \_\_\_\_\_

What concerns have brought you to counseling today? \_\_\_\_\_

### PROBLEMS CHECKLIST

Please rate each with a number: 1= Major Problem 2= Sometimes a problem 3= Never a problem

- \_\_\_\_\_ Feeling accepted by my peers
- \_\_\_\_\_ Learning how to trust others
- \_\_\_\_\_ Feeling bad about the way I look/my body
- \_\_\_\_\_ Getting along with my parents or other family members
- \_\_\_\_\_ Getting a clear sense of what I value
- \_\_\_\_\_ Worrying about whether I am normal
- \_\_\_\_\_ Dealing with sexual feeling and/or problems
- \_\_\_\_\_ Excessive worry or anxiety
- \_\_\_\_\_ Trying to decide on a career
- \_\_\_\_\_ Never eating/eating too much and vomiting to control weight
- \_\_\_\_\_ Dealing with my alcohol or drug abuse
- \_\_\_\_\_ Dealing with problems at school
- \_\_\_\_\_ Dealing with how I feel about myself

Are there any other problems or concerns you would like to address? \_\_\_\_\_

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