Authentic Life
Christian Counseling

INTAKE FORM FOR ADOLESCENT (15-17 Years Old)

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better your therapist will be able to assess your mental health needs. Please provide as much information as possible.

This intake form should be filled out by everyone who is fifteen (15) years of age to seventeen (17) years of age. Parents or Legal Guardians should only help fill out this form if the client consents. The information parents or legal guardians share in this form and the information the minor client shares in this form shall not be disclosed unless the therapist determines it is in the best interest of the minor child to disclose such information in accordance with C.R.S. § 27-65-103 and the Department of Regulatory Agencies' Rules and Regulations.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

Client Information:
Client's Name: _____
Gender: □Male □ Female
Client's Birthdate: _____
Client's Address: _____
City: _____ State:_____ Zip Code: _____
May your therapist) contact you at this address:
□ YES □ NO
Home Telephone: _____ Cell Phone: _____

May your therapist contact you at all the above telephone numbers provided:
□ YES □ NO
_____

May your therapist leave a voice message at all the above telephone numbers provided:
□ YES □ NO
_____
Email Address: _____

Do you share this email address with anyone else? If so please list who else shares the email address:
_____

May your therapist contact you at the above email address: ☐ YES ☐ NO
_____

****Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and/or cell phones. By allowing your therapist to contact you by email you are**

consenting to receive electronic communications and understand the risks involved. Your therapist cannot guarantee that confidential information shared using electronic communications will remain confidential.

What is your preferred method of communication: □Telephone (H) □ Telephone/Text (C) □ Email

Family Information:

Are your parents: ☐ Married or Civil Union ☐ Separated ☐ Divorced ☐ Living Together

If your parents are no longer together, are either of your parents remarried: ☐ YES ☐ NO
Please list your Stepmother and/or Stepfather's Name and telephone number:

_____

_____

May your therapist contact any Stepmother and/or Stepfather: ☐ YES ☐ NO
Mother's Name: _____
Mother's Telephone: _____
Mother's Address: _____
Mother's Occupation: _____

Do you live with your Mother: ☐ YES ☐ NO

If yes, do you live with her ☐ Full-Time ☐ Part-Time

May your therapist contact your Mother: ☐ YES ☐ NO
Father's Name: _____
Father's Telephone: _____
Father's Address: _____
Father's Occupation: _____

Do you live with your Father: ☐ YES ☐ NO

If yes, do you live with her ☐ Full-Time ☐ Part-Time

May your therapist contact your Father: ☐ YES ☐ NO

Do you have any siblings: □ YES □ NO How many? _____ Ages:_____
Do you live with all your siblings: □ YES □ NO
If no, who do your other siblings live with:

_____

_____

Are there any other persons that live in your home with you: □ YES □ NO
If yes, please list their names and ages, and any relationship to you:

_____

_____

Emergency Contact Information:
In case of an emergency, your therapist may be required to contact someone on your behalf. Please list your emergency contact below, which your therapist may contact on your behalf. Your therapist will share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: _____

Telephone Number: _____
Relationship to Client: _____

Client's Hobbies and Interests:
Do you work: □ YES □ NO
If yes, please state where you are employed:_____
Do you play any sports or musical instruments: □ YES □ NO
If yes, please list what sports and/or musical instruments you play:
_____
_____

Please list any other hobbies or interests that you have:
_____
_____

How do you normally spend your day? What does a typical day look like for you?
_____
_____
_____

What school do you attend and what grade are you in:
_____
_____

What is your favorite subject taught in school:
_____
_____

Primary Care Physician Information:
In order to provide you with continuous and congruent care, your therapist may need to contact your primary care physician. Any contact that your therapist may have with your Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: _____
Telephone Number: _____ Fax: _____
Address: _____
Please Provide the Date of Your Last Physical: _____
May your therapist contact your physician: □ YES □ NO
Please list any medication you are currently taking (if you are not currently taking any medications, please state that you are not currently taking any medications):
_____
_____
_____

Please list any current physical illnesses, issues, and/or ailments you have (if you do not currently have any physical illnesses, issues, and/or ailments, please state so):
_____

_____
_____

Previous/Current Mental Health Provider(s):
In order to provide you with continuous and congruent care, your therapist may need to contact your previous or current Mental Health Provider. Any contact that your therapist may have with your previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.
Name: _____
Telephone Number: _____ Fax: _____
Address: _____
Please Provide the Date of Your Last Session: _____

May your therapist contact your previous or current Mental Health Provider: □ YES □NO
Are you currently in counseling with the above listed mental health provider: □ YES □ NO
Have you ever sought counseling before: □ YES □ NO
If yes, please list your reason(s) (if you are currently seeing another mental health provider, please list the reason(s) here as well):
_____
_____
_____

Client's Mental Health:
Please tell us why you are seeking counseling and describe any issues/problems that led you to seek counseling:
_____
_____
_____

How have you dealt with these issues/problems in the past:
_____
_____

Please list any past or current issues that may affect your mental health:
_____
_____

Have you ever been, or are you currently, suicidal:
_____

Have you ever attempted to commit suicide:
_____

Has anyone in your family ever attempted or committed suicide:
_____

Have you used, or do you currently use, alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones):

_____

_____

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate): □ YES □ NO

_____

_____

Have you ever gotten in trouble at school? If so, please describe the circumstances and what happened afterwards:

_____

_____

Are you currently involved in any civil or criminal legal proceedings: □ YES □ NO
If yes, please state the circumstance(s):

_____

_____

Are there any weapons available or unlocked in your home:
□ YES □ NO □ Prefer not to Answer
If yes, please list the weapon, where it is located, and who it belongs to:

_____

_____

Do you have a preoccupation with weapons, violence, killing, or fire:
□ YES □ NO □ Prefer not to Answer
If yes, please describe:

_____

_____

Is there anything else you would like your therapist to know:

_____

_____

What would you like to accomplish through therapy and/or what goals would you like to achieve:

_____

_____

Client Affirmation:
By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

_____ _____
Client Signature Date

_____
Printed Name

CHECKLIST OF CONCERNS

Client Name:_____

Please mark all of the areas of concern below that apply to you. You may add a note or details in the space next to the concerns checked.

CONCERN	NOTES	NOW	IN THE PAST
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Career concerns, goals, and choices			
Childhood issues (your own childhood)			
Codependence			
Confusion			
Compulsions			
Custody of children			
Decision-making, indecision, mixed feelings, putting off decisions			
Delusions (false ideas)			
Dependence			
Depression, low mood, sadness, crying			
Divorce, separation			
Drug use—prescription medications, over-the-counter medications, street drugs			
Eating problems—overeating, undereating, appetite, vomiting, (see also "Weight and diet issues")			
Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Financial or money troubles, debt, impulsive spending, low income			
Friendships			
Gambling			
Grieving, mourning, deaths, losses, divorce			
Guilt/Shame			
Headaches, other kinds of pains			
Health, illness, medical concerns, physical problems			
Housework/chores—quality, schedules,			

sharing duties			
Inferiority feelings			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			
Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nervousness, tension			
Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Parenting, child management, single parenthood			
Perfectionism			
Pessimism			
Procrastination, work inhibitions, laziness			
Relationship problems (with friends, with relatives, or at work)			
School problems (see also Career concerns			
Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			
Sexual issues, dysfunctions, conflicts, desire differences, other (see also “Abuse”)			
Shyness, oversensitivity to criticism			
Sleep problems—too much, too little, insomnia, nightmares			
Smoking and tobacco use Spiritual, religious, moral, ethical issues			
Stress, relaxation, stress management, stress disorders, tension			
Suspiciousness, distrust			
Suicidal thoughts (You or a relative)			
Temper problems, self-control, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			

Weight and diet issues			
Withdrawal, isolating			
Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition			

Client Affirmation:

By signing this Intake Form, I certify that all the information is true and accurate to the best of my knowledge.

_____ _____

Client Signature Date

OPTIONAL For the Parent or Legal Guardian:

In Colorado, an adolescent that is fifteen (15) years old or older may consent to receive mental health services without a parent or legal guardian's consent. You, as a parent or legal guardian, are not required to fill out the below information; however, by providing this information your minor child's therapist may be able to better assess your minor child's mental health needs.

What brings you and your minor child in today? What do you hope for your child to accomplish in counseling?

_____
_____
_____
_____

Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate): □ YES □ NO

_____
_____

Are there weapons in your home: □ YES □ NO □ PREFER NOT TO ANSWER

If yes, please list the weapon, who owns the weapon, where it is located, and whether it is secured:

_____
_____

Are there any restraining orders that your therapist should be aware of: □ YES □ NO
If yes, please provide a copy of the restraining order and describe the circumstances under which it was ordered):

_____
_____

If you are divorced or separated, please list who has decision-making authority and custody over the minor child. Please include a copy of the court custody order or custody agreement.

_____
_____

Who will be dropping off and picking up the minor child at Authentic Life Christian Counseling:

_____
_____

*Does your minor child's therapist have permission to discuss administrative details, such as appointments and scheduling with this person: □ YES □ NO
A separate Authorization for Release of Information will be required to discuss any details with the above named individual.
Is there anyone that should **NOT** pick up the minor child at Authentic Life Christian Counseling:

_____
_____

Please be aware that anyone over the age of fifteen (15) years old must consent to receive mental health services. As such, your minor child must sign this intake form and their therapist's Disclosure Statement. It is within the therapist's sole discretion to advise you of the services given to or needed by the minor child and/or provide you with a treatment summary.

Parent or Legal Guardian Affirmation:
By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Relationship to Client Date

_____ _____
Adolescent Client's Signature Date