YOUTH INTAKE FORM **Today's Date: _____**

Please fill out this form as completely as possible using clear, printed writing.
All information is confidential.

Demographic Information

Name: _____ Birth Date: _____
(First) (Middle) (Last)

Phone Number: _____ Email: _____

Preferred method of communication (check any that apply)
Call Text Email Other:_____

Emergency Contact::_____
(Name) (Relationship) (Phone #)

Mailing Address: _____
(Street #) (City) (Zip)

Home Address: _____
(if different) (Street #) (City) (Zip)

School: _____ Grade:_____

Payment and Insurance Information: Have a Parent/Guardian help you fill out this section

Responsible Party: _____
(First) (Middle) (Last)

Address: _____
(Street #) (City) (Zip)

Relationship to Client: _____Phone: _____

Primary Insurance:_____ Identification #:_____Policy/Group #:_____

Primary Holder name: _____ Date of Birth:_____
(if other than client) (first) (Middle) (Last)

Policy Holder SSN:_____ Employer:_____

Current Concerns

Please briefly summarize what brings you to counseling

._____
_____

Please describe what you are hoping for in the treatment process.

_____
_____

Would you like anyone to attend the sessions with you.

_____
_____

Do you or someone in your family have a current mental health diagnosis:
☐No ☐Yes: Explain_____

Are you or someone in your family currently taking any medications for this or other issue?
☐No
☐Yes:Name:_____Reason_____

Have you participated in therapy before?
☐No ☐Yes: Explain_____

If yes, briefly summarize any helpful aspects of the experience:

_____
_____

Do you plan to work with another therapist at the same time?
☐No ☐Yes:
Explain_____

Are you concerned you or someone you care about has an unhealthy relationship with alcohol?
☐No ☐Yes:
Explain_____

Are you concerned you or someone you care about has an unhealthy relationship with marijuana?
☐No ☐Yes:
Explain_____

Are you concerned you or someone you care about has an unhealthy relationship with prescription drugs?
☐No ☐Yes:
Explain_____

Are you concerned you or someone you care about has an unhealthy relationship with other illicit drugs?
☐No ☐Yes:
Explain_____

Are you concerned you or someone you care about is self-harming or having thoughts about wanting to die?
☐No ☐Yes:
Explain_____

Other Health Information

Physician:_____Phone #: _____
Address: _____

Psychiatrist: _____Phone #: _____
Address: _____

Do you have any current health concerns:
☐No
☐Yes:
Explain_____

Are you currently taking any medications for your health concerns?
☐No ☐Yes: Name:_____Reason_____

Do you have any significant past health concerns:
☐No ☐Yes: Explain_____

Do you have any allergies?
☐No ☐Yes: Explain_____

If applicable, are your menstrual cycles regular?
☐Yes ☐No:Explain_____

Family Information

Please consider answering the following questions.

What ethnicities do you identify with? _____

What is your education level? _____

What religion do you identify with? _____
Are you currently a member of a congregation? _____

What gender do you identify with? _____

What sexual orientation do you identify with? _____

Do you identify as transgender? ☐ Yes ☐ No ☐ Prefer not to say

Relationship Status: Single In-a-relationship

Partner Name:_____ Age: _____
Length of relationship: _____ School: _____

Siblings (please list oldest to youngest)
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____
Name: _____ Birthdate: _____

Thank you!