Monument
Christian Counseling LLC

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YOUTH INTAKE FORM

Date: _____ **Date of Birth:** ____ /____ /____ **Age:** _____

Name: _____

Guardian or Foster Parent: _____

Address: _____ City: _____ Zip: _____

Phone: _____

Biological Mother: _____

Address: _____ City: _____ Zip: _____

Phone: _____

Biological Father: _____

Address: _____ City: _____ Zip: _____

Phone: _____

What brings you to counseling at this time? _____

_____

_____

What are your goals for therapy? (i.e., if therapy is successful, what are you hoping will be different about your life?) _____

_____

_____

What are your strengths that will assist you in reaching your goals? _____

_____

Have you ever been to counseling before? ☐ Yes ☐ No If yes, when? _____

Give a brief description of issues worked on: _____

_____

List any significant health problems: _____

_____

Are you currently taking prescription medications? ☐ Yes ☐ No

Medication	Dosage	Medication	Dosage

SELF HISTORY

Do you currently use drugs or alcohol? ☐ Yes ☐ No If yes, how often? _____

Have you ever been in a drug, alcohol or other treatment program? ☐ Yes ☐ No (if you are comfortable, briefly describe.) _____

_____

Have you ever engaged in self harm? ☐ Yes ☐ No If yes, list methods _____

_____

Have you ever thought about completing suicide? ☐ Yes ☐ No (if you are comfortable, briefly describe.)

_____

_____

What kind of support system do you have? _____

What are your interests and hobbies? _____

_____

Has there been a death of someone close?

Relationship	**When**	**Relationship**	**When**

Child Abuse? ☐ Physical ☐ Sexual ☐ Emotional ☐ Neglect

Sexual Assault/Rape? ☐ Yes ☐ No

Please check any current or past issues:

☐ Dating	☐ Work	☐ Self-control	☐ Health
☐ Finances	☐ Assertiveness	☐ Career choices	☐ Eating disorder
☐ Spiritual concerns	☐ Violence	☐ Legal issues	☐ Parenting
☐ Separation/divorce	☐ My past	☐ Grief	☐ Family
☐ Parents	☐ Stress		

Other areas: _____

_____

If you currently experience any of the following symptoms, please rate them using the key below:

0 = Never **1 = Sometimes** **2 = Often** **3 = Always**

Difficulty concentrating _____	Lying to others _____	Panic attacks _____
Crying _____	Feeling out of control _____	Obsessiveness _____
Missing work/classes _____	Feeling self-doubt _____	Anger _____
Feeling uptight/edgy _____	Memory loss or blackout _____	Guilty feelings _____
High energy level _____	Feeling hopeless _____	Nightmares _____
Difficulty sleeping _____	Withdrawing socially _____	Feeling afraid _____
Low energy level _____	Hearing voices _____	Worrying _____

Physical symptoms (e.g., headaches, digestive, muscle tension) _____

_____

_____

Last Grade Completed:

☐ Less than Grade 5
☐ Grades 5-6
☐ Grades 7-8
☐ Grades 9-10
☐ Grades 11-12
☐ GED
☐ Some College
☐ School Program (does not have grade levels)
☐ Do not know

School Status:

☐ Attending school regularly
☐ Dropped out
☐ Expelled
☐ Don't know
☐ Attending school irregularly
☐ Suspended
☐ Graduated High School

Name of School attending: _____

Are you employed? ☐ Yes ☐ No

If yes, where? _____ Supervisor _____

Address: _____ City: _____ Zip: _____

Schedule of hours currently working: _____

FAMILY HISTORY

In your family, is there a history of:

- ☐ Mental illness
- ☐ Substance abuse
- ☐ Divorce
- ☐ Alcoholism
- ☐ Domestic violence
- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Neglect
- ☐ Suicide/Suicidal attempt
- ☐ Custody issues

How were you referred to this office?

- ☐ Self-referral
- ☐ Street outreach
- ☐ Residential program
- ☐ Other public agency or program
- ☐ Law enforcement/Police
- ☐ Mental Hospital
- ☐ Other private organization
- ☐ Individual (other adult or relative)
- ☐ Dept. of Human Services
- ☐ Hotline
- ☐ Juvenile Justice
- ☐ Religious organization
- ☐ School Name: _____
- ☐ Other: _____

Referral Source Name: _____ Phone:_____