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Adolescent/Young Adult Intake Form

Date _____

Family Information

	Name	DOB	Contact: (* preferred)
Young Adult			Home: Cell: Email:
Mother			Home: Work: Cell: Email:
Father			Home: Work: Cell: Email:
Sibling			Cell:
Sibling			Cell:

Parents: ____ Married ___ Unmarried ___ Live together ___ Live Separately

Family Address (s)

_____

Street City Zip

_____

Street City Zip

Referred by_____ Phone_____

Parent's Relationship Status:
Single_____Separated_____Widowed_____Married/Significant Other_____Divorced____

Other_____

If divorced or separated, how long?_____Still in contact? YES NO

Name of Emergency Contact_____Relationship_____
Day Phone_____

Education:
Last grade completed_____Current School_____

Previous Therapy/Treatment? YES NO If yes,

When_____Where_____

With Whom_____Presenting Problem_____

Outcome_____

Medication or Medical Care_____

Presenting Problem (Why are you, the parent here?)

_____

_____

_____

_____

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_____

_____

Chemical Dependency History (your best guess regarding young person)

USED?	When First	Most Recent	How Much/Often	Method of Use
Marijuana	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Speed/Meth/Amphetimines	_____	_____	_____	_____
Cocaine/Crack	_____	_____	_____	_____
Benzodiazapenes (Valium, Xanax, Klonopin, etc)	_____	_____	_____	_____
Morphine (Heroin, Codeine, Vicodin, Percoset, Oxy etc)	_____	_____	_____	_____
LSD, Ecstasy, Mushrooms	_____	_____	_____	_____
Other	_____	_____	_____	_____

How has substance use caused him/her trouble?

1. Weight gain/loss	yes	no	7. Legal problems	yes	no
2. Vomiting after use	yes	no	8. Heart problems	yes	no
3. Blackouts	yes	no	9. Diabetes	yes	no
4. Attempts to control use	yes	no	10. TB	yes	no
5. Family problems	yes	no	11. Sight/hearing disability	yes	no
6. School problems	yes	no	12. Other_____		

Is there a history of physical, emotional, and/or sexual abuse? YES NO If YES, please explain:

_____

Has he or she ever considered suicide?_____

Has there been any suicide attempts?_____

How?_____When?_____

Number of attempts_____

Is he or she suicidal now? YES NO

Have he or she ever been violent towards another person?

Explain_____

_____

On probation? YES NO

If yes, please complete the following:

Probation Officer_____Phone_____

Requirements_____

Please list all prescription and over-the-counter medications he or she is currently taking or has taken in the past 30 days. (Include amount and frequency)

_____

_____

As parent, are you the child of an alcoholic or addict? YES NO

Family of Origin History

Genetic family History: Alcohol, Nicotine, Drugs, Depression Suicide, and Eating Disorders

Family Member	Problem	Did they Receive Treatment?
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO
_____	_____	YES NO

Other information you feel would be helpful: