ENCOURAGE counseling

Safe Space…Deep Healing

1189 South Perry Street, Suite 140, Castle Rock, Colorado, 80104 * 720-230-3076

COUNSELING INTAKE FORM – ADOLESCENT (13-17 years old)

enCOURAGE Counseling, LLC asks that you complete this form to the best of your ability. It is intended for use by clients under the age of 15, as well as those ages 15 – 17 who are being presented by their parent(s) for counseling. **There are separate sections for the parent/guardian and the minor child to complete, as able.** While you are not required to supply the information requested, know that the more you share, the better I am able to meet your specific needs. This information may be considered confidential; however, certain otherwise confidential information may be shared as required by law. The completed intake form will be kept in the client file and maintained under the same confidentiality protection as the therapeutic record, as detailed in the enCOURAGE Counseling Disclosure Statement and HIPAA Form.

Parent/Guardian Section- Pages 1 – 7 **Adolescent Client Section – Pages 8-9**

Demographics & Contact Information

_____ _____
Client Name Date of Birth

_____ _____ Gender: ☐Male ☐Female ☐Other:_____
Age Ethnicity

_____
Street Address, City, State, Zip Code

_____ _____
Mother Name Mother Phone

_____
Street Address, City, State, Zip Code

_____ _____
Father Name Father Phone

_____
Street Address, City, State, Zip Code

_____ _____

Guardian Name Guardian Phone

_____

Street Address, City, State, Zip Code

_____ _____

Emergency Point of Contact (POC) **Emergency POC Phone**

_____

Relationship to Client

Minor Child lives with: (Please check all that apply)

☐ Father ☐ Mother ☐Both Biological Parents ☐Both Legally Adoptive Parents

☐Stepfather ☐Stepmother ☐Relatives: _____

☐Other: _____

In the case of divorced parents, who has legal custody of the minor child? _____

_____

□ **THERAPIST: Obtain a copy of the custody agreement/order.**

Who else lives in the home (siblings, relatives, significant others, etc.)? _____

_____

_____ _____

Physician Name Phone

_____ _____

Psychiatrist/Prescriber Name Phone

_____ _____

Previous Counselor Name Phone

Please note that in accordance with applicable HIPAA and Colorado regulations, we will not contact your physician, psychiatrist, or counselor with your knowledge and consent.

Is the <u>minor child's</u> primary insurance Medicaid? Y or N

How did you hear of enCOURAGE Counseling? _____

What led you to seek counseling for your child? _____

_____

How long has this been a significant problem for your child? _____

Please describe any incidents or situations that may have contributed to this issue (e.g. school, trauma, divorce, relationships, etc.): _____

_____

_____

Please describe your child's strengths, weaknesses, general behavior, and attitude: _____

_____

_____

Please rank your child's current attitude about coming to counseling:

1 2 3 4 5 6 7 8 9 10
(resistant) (mildly interested) (highly interested)

What part does faith, religion, or spirituality play in your family's life? _____

_____

Do you attend a place of worship? □YES □NO If so, where? _____

Among your child's friends and family, who provides support (emotional, spiritual, financial, etc.)?

_____

Self Harm

Has your child had thoughts of harming him/herself or others? □YES □NO If yes, please explain:

_____

_____

Has your child ever seriously considered suicide or attempted suicide? □YES □NO
If yes, please explain:

_____

Does your child have the intent and means to commit suicide now? □YES □NO If yes, please explain:

_____

Does your child have the intent and means to harm or kill someone other than him/herself right now? □YES □NO If yes, please explain:

_____

Medical and Mental Health History

Is your child experiencing any physical symptoms such as over/under eating, sleeping problems, chest pain, anxiety, depression, shortness of breath, etc? □YES □NO If yes, please explain:

_____

_____

Are there any significant past or present **health or medical issues** that I should be aware of? □YES □NO If yes, please explain:

_____

_____

Are there any significant past or present **mental health issues** that we should be aware of? □YES □NO If yes, please explain:

_____

_____

Are there any significant past or present **developmental issues** that we should be aware of? □YES □NO If yes, please explain:

_____

Has your child ever experienced **abuse** (emotional, physical, and/or sexual)? □YES □NO
If yes, please describe, to include dates and relationship of the abuser: _____

_____

Has your child experienced other types of **trauma**, to include concussion? □YES □NO
If yes, please describe: _____

_____

Has your child experienced **flashbacks** concerning trauma? □YES □NO
If yes, please describe: _____

_____

Medication, Substance Use, and Addiction

Please list all medications your child is now taking and/or has taken in the past 3 months:

Medication	***Dosage***	***Prescriber***	***How long?***	***Helpful?***	***Reason/Comments***

Please indicate whether your child uses (or has used in the past) the following substances:

Tobacco/Vaping □YES □NO Starting age/Extent: _____

Marijuana □YES □NO Starting age/Extent: _____

Drugs □YES □NO Starting age/Extent: _____

Drug(s) of Choice: _____

Alcohol □YES □NO Starting age/Extent: _____

Other □YES □NO Starting age/Extent: _____

Substance(s) of Choice: _____

Does your child have other addictions, such as food, gaming, shopping, porn, etc.? □YES □NO

If yes, please explain: _____

_____

Has your child been in any substance/process addiction treatment programs? □YES □NO

If yes, please explain: _____

_____

Family of Origin Questions

Describe your child's immediate family (e.g. parents, siblings, ages, etc.): _____

_____

_____

Does your child's family, whether biological or adopted, struggle with mental illness, chemical dependency, suicidality, etc.? □YES □NO If yes, please explain: _____

_____

_____

Other Questions

Does your child have a preoccupation with weapons? □YES □NO If yes, please explain:

_____

Are there weapons unlocked/accessible in the home? □YES □NO If yes, please describe:

_____

_____

Are there incidents of fire setting or animal abuse in your child's history? □YES □NO If yes, please describe:

_____

Please describe your child's friends: _____

_____

What else would you like me to know about your child? Consider changes in behavior, relationships, hobbies, interests, activities, socialization, etc.: _____

_____

_____

_____

Parent/Guardian and Adolescent Signatures

_____
Parent/Guardian #1 Printed Name

_____ _____
Parent/Guardian #1 Signature Date

_____
Parent/Guardian #2 Printed Name

_____ _____
Parent/Guardian #2 Signature Date

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date
Laurie A. Marcellin MA, LPC, NCC, CATP

Adolescent Section

Parents, please make a copy of this for your teen so they can complete it and bring it to the first session. Please DO NOT ask to see their responses.

Your name _____ Birthdate _____Age _____

Cell number _____ email _____

Current Concerns

What brings you in today? _____

How long has this been a significant problem for you? _____

How would your friends/family describe you?_____

_____

Home Environment

Do you have rules at home? □YES □No Which rule do you struggle with the most? _____

What typically happens if you break a rule at home: □Grounded □Loss of phone/tech □Yelling □Loss of car or privileges □Nothing □Other (describe): _____

Have you experienced any of the following **traumas** (*check all that apply*): □Death of a parent □Death of a family member or friend or pet □Divorce □Bullied □Physical abuse □Sexual abuse/assault □Loss of home □Loss of friend/group of friends □Virtual trauma (bullying, photos distributed, etc.) □ Suicide attempt of yourself or family member

_____

PERSONAL HISTORY CHECKLIST

Please check any sentences that make sense and describe you. ***If there is anything you don't feel like you can answer****, leave it blank and we can talk about it during your first session.*

___I don't let other people know how I'm feeling.
___I feel depressed most of the time.
___I feel anxious at school. ___I feel anxious at night. ___I feel anxious when I'm around crowds.
___I've tried to hurt myself with cutting, burning, scratching, and other ways.
___I have self injured or thought about suicide in the last 24 hours.
___I can't sleep. I struggle to get to sleep or to stay asleep.
___I can't sleep. I smoke pot or drink to fall asleep.
___I think about dying and the problems that would solve.
___There are things about myself I hate.
___If you really knew what I'm like, you would not like me.
___I don't want to be in therapy.
___I'm afraid to tell my parents or friends what is really going on with me. If they knew, they wouldn't like me or love me anymore.
___I feel invisible.

___I avoid school (or other problems) by cutting classes, sleeping, hiding through the day.
___I have been betrayed by friends.
___I've been bullied.
___I've bullied other kids.
___I used to love school, and now I'm struggling or failing.
___School is really easy for me.
___School is really hard for me.
___I've been suspended or expelled.
___I've gone to more than one school in the past two years.
___I've been in fights at home or school or in public.
___I used to be really popular, and now I have no friends.
___I feel alone most of the time.
___I'm tired of the drama with my family.
___I'm tired of the drama with my friends.
___I used to be really involved in activities (4H, sports teams, clubs, youth groups, music), but now I have no desire to do any of them.
___I have cut people out of my life and never spoken to them again.
___Sometimes I don't remember what has been happening in class, at home or with friends.

___I am sexually active or I've been sexually active.
___I think that I may be gay or bisexual.
___I watch porn.
___I've experienced sexual trauma. I was molested, assaulted or raped.
___My parents or important adults in my life have never talked to me about sex, sexuality or other important topics I want to know about.
___The way my parents or other adults talk about sex, I'm afraid and ashamed to ask them.
___I think my body is disgusting.
___I withhold food from myself or exercise a lot when I think I'm too fat.
___Sometimes I can't stop myself from eating.
___I am disgusted by food and can't eat most of what is at home.
___I look at pro-ana and pro-mia websites.
___I have to do everything perfectly. Sometimes that means I don't finish homework or tasks.
___I regularly use pot, alcohol, vaping, smoking tobacco.
___I think about/have planned how to run away from home.
___I've been arrested.
___My relationships are mostly through gaming and social media.
___I feel like I'm a different person depending on who I'm with.
___I've been to the psych hospital for _____.

___I have great friends who care for me.
___I'm exhausted after being around people, even if it's just for an hour or two.
___I love being around people like my friends, family, crowds.
___I am on my phone and/or social media at least 4 hours a day.
___ I like who I am.
___I have/have had a boyfriend or girlfriend.
___I have a best friend.

Thank you for answering all of these questions! Take a moment and tell me how you're feeling after answering them: I feel _____. I think _____.
I'm looking forward to meeting you at our first session!