## BODY APPRECIATION AND SELF–KINDNESS, LLC

## CONFIDENTIAL ADOLESCENT INTAKE INFORMATION

Pt1-to be completed by caregiver

**CLIENT INFORMATION** **DATE:_____**

Client/Adolescent Legal Name:_____

Parents' Marital Status:_____

Parent #1 Name, Phone Number:_____

Parent #2 Name, Phone Number:_____

Parent(s) with Legal Custody:_____

Please describe custody arrangements (if applicable):_____

Home Address:_____

City_____State_____Zip_____

Is it ok to contact you by phone? Yes/No

Is it ok to leave a voicemail message? Yes/No

Preferred phone number: _____

Email Address:_____

**For Emergency Use:**

Nearest relative or friend who does not live with you:

_____

Relationship_____Phone_____

Address_____City_____State_____Zip_____

Why are you seeking therapy for your child? How long has this problem persisted?

_____

_____

_____

Why are you seeking therapy now?_____

_____

How were you/ the client referred to therapy?_____

Referring provider (if applicable)_____

**Counseling History**:

Previous counseling? Yes/No

Has your child seen a counselor/therapist, clinical psychologist, psychiatrist? (Circle all that apply)

Where and what was the name of your child's previous provider?

_____
_____
_____

Dates Seen:_____
What was your child seen for?_____
_____
Was it helpful? Why or why not?_____
_____
Why did it end?_____
_____

Has your child been hospitalized for psychiatric reasons? If so, for what, where and when? _____
_____

**Medication History:**

Current medication(s), including over the counter, vitamins, herbal supplements:_____
Current Prescriber (if applicable):_____
Give name, quantity, reason(s) _____
Past medications and what they were treating:_____
_____
_____

**More History:**

Where was your child born? _____
Name of your child's school_____
Teacher/Grade:_____
School status: Full-time_____ Part-time_____Online program? Y/N
Did or does your child have any problems in school? Please describe._____
_____
_____
Does your child have and IEP/504/ Special Education? If so, for what?_____Since when?_____
Name of counselor/psychologist who coordinates IEP/504/special education recommendations:_____

Your child's
Primary Care Provider:_____
Psychiatrist:_____
Other:_____

**Family Members**

| Name | Age | Relationship | Grade/Occupation | Living at home |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

I will provide you with a Developmental History form where you can add any additional concerns or points that you would like me to know to inform treatment.

Thank you so much!

**BODY APPRECIATION AND SELF–KINDNESS, LLC**

**CONFIDENTIAL ADOLESCENT INTAKE INFORMATION**

**Pt 2-to be completed by the adolescent client:**

Preferred Name:_____

Sex: M/F/X Marital Status_____ DOB_____AGE_____

Preferred Name: He ☐ She ☐ They ☐ Ze ☐ Pronoun not listed ☐

No pronoun preference ☐

Gender Identity: Female ☐ Male ☐ Trans Female ☐ Trans Male ☐

Genderqueer/ Gender Non-conforming ☐ Other ☐

Why are you seeking therapy? What do you want to make better in your life?_____

_____

How do you feel about being here?_____

Siblings? Y/N

If so, how many?_____Ages:_____

How would you describe your relationship(s) with your sibling(s)?_____

_____

Who is a part of your social support/circle? How do you feel about our friends/social connections?_____

_____

How do you like school? Are you having any struggles in school? If so, what kind?_____

_____

Do you have any medical Problems? Yes/No

Explain_____

What do you like to do for fun?_____

How much physical activity do you get each week and what do you like to do for exercise?_____

What helps you feel happy?_____
How do you like to relax and de-stress?_____
How is your appetite?_____
How is your sleeping? How much sleep do you get?_____
What are some positive things that you like about yourself?_____
_____
_____
What other points would you like to address or would like me to know to help our working together?
_____
_____
_____

Thank you for taking the time to complete this intake form. I am looking forward to our working together.