



FRIENDS OF THE FAMILY MINISTRIES

Adolescent Intake Form

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DIRECTIONS: Please complete this form as thoroughly as possible. The information will enable us to help you more quickly and efficiently.

Today's Date: _____

Client Name: _____

Age: _____ Date of Birth: _____

Street Address: _____

City/Zip Code: _____

Phone Number: _____ OK to leave message? Yes No (circle one)

Parents'/Legal Guardian Names: _____ ; _____

Street Address: _____

City/Zip Code: _____

Phone Number: _____ (Home) OK to leave message? Yes No

_____ (Work) OK to leave message? Yes No

Employer/Occupation: _____

What school do you attend? _____ Current Grade: _____

Special Education plan? _____

What do you like most about school?

What do you like least about school?

What is your favorite subject?

What subject do you like the least?

What other kinds of things do you like to do?

Have you ever been to counseling before? If so, please list name(s) of previous counselor(s) and the dates you received their services.

What problems bring you in for counseling now? How long have you experienced them? Do things seem to be getting better, worse, or staying the same?

Please check any and all of the following areas that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Bingeing on food |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Feeling worthless | <input type="checkbox"/> Feeling sad |
| <input type="checkbox"/> Fearful dreams | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Heart racing | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Your mind is racing | <input type="checkbox"/> Anger/Aggression |
| <input type="checkbox"/> Loss of interest in activities | <input type="checkbox"/> Feeling confused |
| <input type="checkbox"/> Sexual thoughts/fantasies | <input type="checkbox"/> Other (please explain): |

Ever wanted to hurt yourself, or think that you didn't want to live anymore? (please explain)

Ever wanted to hurt someone else? (please explain)

Where did you learn about sex?

Have you been sexually active? Yes No

Ever pregnant? Yes No

FAMILY HISTORY

Where were you born?

Have you ever lived anywhere else?

Please list the people you currently live with and their relationship to you (mom, dad, brother, etc.)

NAME	AGE	OCCUPATION	RELATIONSHIP
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Please list parents, brothers, or sisters who do not currently live with you:

Please describe your relationship with the following people:

Mom:

Dad:

Brother(s):

Sister(s):

Step-brother(s)/Step-sister(s):

MEDICAL INFORMATION

Have you ever been hospitalized? If so, please explain.

Who is your doctor?

When was your last visit to your doctor? For what reason?

Do you currently take any kind of medication? (please list type and how much)

DRUG/ALCOHOL HISTORY

Please describe how often you use the following:

alcohol: ___ drinks per day; ___ drinks per week. Is this more or less than you drank last year?

What type of alcohol do you drink (beer, wine, etc.)?

How many times have you been drunk in the last six months? _____ In the past year? _____

Anyone in your family have problems with alcohol or other drugs?

Use marijuana: ___ every day; ___ times per week; ___ times per month.

Is this more or less than 6 months ago?

Other kinds of drugs you have tried or are currently using (please list type & how much/how often):

TRAUMATIC EVENTS

Please list any significant traumatic events that have happened in your life. These may include sexual abuse, emotional abuse, physical abuse, abortion, divorce in your family, life-threatening events, etc. You can be brief...we'll talk more about it in your sessions.

GOALS

What would you like to see happen as a result of coming to counseling?

What do you think your parents or others want for you in coming to counseling?

Tell us a little about your religious upbringing

Please indicate which of the following you are involved in:

- church attendance
- Bible study
- youth group
- other (please explain)

Please describe what you believe about God

Would you like prayer and/or Bible scripture incorporated in counseling sessions?