DAYMARK
PASTORAL COUNSELING

Adolescent Intake & Questionnaire

Name:_____ Sex_____ Birth Date_____

Cell Phone: _____ Email: _____

Address_____
(Include street, city and zip)

IF DEPENDENT CHILD – Are custodial parents Married Separated Divorced

CHILD AND ADOLESCENT CONSENT FOR TREATMENT (Legal Guardian MUST sign if primary patient is under 18 years old).

I certify that I am the: Father Mother Legal Guardian of the above child/adolescent.
I certify that I do have the legal custody of the above named child/adolescent and give my authorization for the above named child/adolescent to receive outpatient counseling.

Name (please print):_____

Signature:_____ Date: _____

IN CASE OF EMERGENCY PLEASE NOTIFY:
_____
(Name)(Phone) (Relationship)

Daymark Pastoral Counseling sends out a quarterly newsletter that contains short articles, book reviews and news about the ministry.
_____ Yes, send me the newsletter to the email address listed above.
_____ Yes, send me the newsletter via snail mail to the address listed above.
_____ No, I would not like to receive the newsletter.

DIRECTIONS: Please answer the following questions as fully as possible.
How do you feel about being here?
- It's fine with me, I need to be here
- I don't care either way
- I don't want to be here

Please explain as applicable:
_____
_____
_____

What event(s) or problem(s) have caused you to come for counseling?

_____
_____
_____

What to do you hope to gain/will change as a result of attending counseling?

_____
_____
_____

Health

Please check all that apply to you:

- o I have difficulty falling asleep
- o I wake up frequently during the night
- o I wake up very early and I can't get back to sleep
- o I feel tired most of the time
- o I cry or am teary more than most
- o I have gained or lost 10 pounds or more within the past two months
- o I sometimes eat way *too much* or *too little* (circle which applies) or I feel my eating habits are out of control.
- o I sometimes vomit after eating too much to get rid of food
- o I have a hard time concentrating
- o My memory is not as good as it used to be
- o I have stomachaches a lot
- o I have headaches a lot
- o I have thoughts that trouble me sometimes or its hard to let go of certain thoughts no matter how hard I try
- o I worry a lot
- o Sometimes I wish I didn't have to go on living
- o I have a lot of things in my life that I am angry about
- o I have moments where I feel as though I am watching myself or feel detached from my body

Check the five (5) feelings you experience most often:

o Happy	o Sad	o Angry	o Irritable
o Anxious/Nervous	o Bored	o Confused	o Confident
o Shy	o Hyper/Energetic	o Guilty	o Overwhelmed
o Worried	o Lonely	o Worthless	o Depressed

Suicidal/Homicidal Ideation

Have you attempted to commit suicide or homicide in the past? (Circle: Yes or No)
If yes, how?_____
Is there a history of suicide in your nuclear and/or extended family? (Circle: Yes or No)

Have you ever inflicted burns or wounds to yourself? (Circle: Yes or No)
Have you ever thought about suicide? (Circle: Yes or No)
Are you presently suicidal/homicidal? (Circle: Yes or No)

Family

List the members of your family of origin and how you got along with each one.

Family Member Comment

_____
_____
_____
_____
_____
_____

What was your birth order? ___of ___ children. Who has/is primarily raising you?

_____

Describe your family in a few words:_____

_____
_____

Who do you get along with the best in your family?_____

_____
_____

What would you change about your family if you were given the power to do so?

_____
_____
_____

Have there been any unusual or traumatic experiences for you as a child?

Date Age Event

_____
_____

What is your sexual orientation? Heterosexual Homosexual Bisexual

Faith

Do you currently attend church, synagogue, or mosque? (Circle: Yes or No)
Are you involved in a religious youth group? (Circle: Yes or No)
Have you had any positive or negative experiences related to your faith? (Circle: Yes or No)
Please describe:_____

_____
_____

Friendships and Relationships

How much time do you spend with others your age? (Circle: a lot some not much)
Do you have a "best" friend? (Circle: Yes or No) If so, how long have you known him/her?
_____

Do you have a boyfriend/girlfriend? (Circle: Yes or No) If so, how long have you been dating?
_____

Do people at school tend to label your group of friends? (Circle: Yes or No) If so, what label is your group usually given? _____

Do you have someone you can talk to about personal issues in your life? (Circle: Yes or No) If so, who? _____

Do you use social networking sites such as MySpace, Facebook or Twitter? (Circle: Yes or No)
If so, how much time do you spend checking these sites?_____

How do you generally think of adults? *Please check all that apply*
□ Helpful □ Friendly □ Overly Strict □ Smart or wise most of the time □ Can be trusted or counted on □ Usually Nice □ Out of touch with you □ Caring □ Jerks □ Stupid or dumb most of the time □ Cannot be trusted or counted on □ Usually Mean

School

What school do you go to? _____
What grade are you in/year (freshman-senior)_____
What activities (if any) are you in at school (such as sports, music, ect.)
_____
_____
_____

What do you like the most about school?
_____

What do you like the least about school?
_____

Activities and Interests

What do you do for fun?_____
_____

What activity would you like to do that you haven't done yet in your life?
_____
_____

Treatment History

Have you ever been to counseling before? Please list any previous counseling experiences

(counselors and dates):

_____
_____
_____

Please list any admissions to the hospital for mental health or addiction issues (note dates and reasons for admission):

_____
_____
_____

Medical Information

Please describe your current condition health_____
_____

Are you currently on any medication? (Circle: Yes or No) Please include the name of the medication and the prescribing physician_____
_____

Has it been more than a year since your last physical including blood tests? (Circle: Yes or No)
Do you have any allergies? (Circle: Yes or No) If yes, explain_____
_____

List any previous health problems, operative procedures, and medical hospitalizations:

Problem	Dates	Treatment

Substance Abuse/Addiction History

How often do you?

	Never	I've tried it	Rarely	Monthly	Weekly	Daily
Smoke cigarettes/ E-sigs/vapors						
Drink Alcohol						
Smoke Pot/Marijuana						
Use crack/cocaine						
Use Acid/LSD						

Have you experienced a recent increase in the use of alcohol/other substances? (Circle: Yes or No)

Do you see your current usage as a problem? (Circle: Yes or No) If yes, when did it become problematic?_____

Describe any significant family history of substance abuse:

_____

_____

Nutrition

Have your eating habits changed recently? (Circle: Yes or No) If yes, please describe:_____

_____

Has your weight fluctuated more than +/- 10 lbs. over the previous year? (Circle: Yes or No)
Do you often eat out of depression, boredom, anger? (Circle: Yes or No) If yes, please describe_____

_____

If you use laxatives, water pills (diuretics), or diet medications, how often do you use them?

_____

Legal History

Have you ever had any charges, arrests or convictions? If so, please explain:

_____

_____

Miscellaneous

Are there any other things that can be helpful for us to know about you?_____

_____

_____

_____

_____

_____

_____ _____

Signature **Date**