

## ADOLESCENT INTAKE INVENTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_

SS #: \_\_\_\_\_ Referred by: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Please tell us your contact preferences: \_\_\_\_\_

### PERSONAL INFORMATION

Gender: Female Male Race: \_\_\_\_\_

Sexual orientation: Heterosexual Homosexual Bisexual Prefer not to answer

Leisure and Recreational Activities: \_\_\_\_\_

Sports: \_\_\_\_\_

Grade completed: \_\_\_\_\_ Are you still attending school? Yes No

If yes, what school? \_\_\_\_\_ Schedule: Full time Part time

What is your GPA? \_\_\_\_\_ Do you like school? Yes No

Have you had expulsions or suspensions from school? Yes No

If yes, when? \_\_\_\_\_ Why? \_\_\_\_\_

Do you plan to attend college? Yes No Technical/trade school? Yes No

Are you employed? Yes No If yes, your schedule is Part time Full time

If you are employed, please complete the following:

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please mark the answer that best describes your childhood:

Very happy Happy Average Unhappy Very unhappy

Who is raising you or did raise you (check all that apply):

Biological parents Parent and Step-parent Single parent (mother)

Single parent (father) Relatives Foster parents Unrelated friend(s) of family

Who do you live with now? \_\_\_\_\_

If your parents are divorced, who has custody of you? \_\_\_\_\_

How much time do you spend with the absent parent? \_\_\_\_\_

## RELATIONSHIPS

Mother's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's address if different than yours: \_\_\_\_\_

Mother's employer: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_

Father's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's address if different than yours: \_\_\_\_\_

Father's employer: \_\_\_\_\_ Father's Occupation: \_\_\_\_\_

Are you married?  Yes  No # Previous marriages: \_\_\_\_\_

Are you living with a partner?  Yes  No # Previous live-in companions: \_\_\_\_\_

If married, please answer the following:

Spouse's name: \_\_\_\_\_

Is your spouse living with you?  Yes  No

If not married, which best describes your relationship status:

Live-in companion  Dating  Engaged to be married  No involvement

Are you happy with your relationship status?  Yes  No  Prefer not to answer

Have you ever been pregnant?  Yes  No Are you pregnant now?  Yes  No

# Full-term pregnancies: \_\_\_\_\_ # Abortions: \_\_\_\_\_ # Miscarriages? \_\_\_\_\_

Are you raising any of your children? \_\_\_\_\_

List all family members who are living in the same household:

Name of household or family member	Age	Relationship to you

## HEALTH INFORMATION

### LIST ALL YOUR MEDICATIONS AND THE PURPOSE FOR TAKING THEM ON THE SEPARATE FORM PROVIDED.

Who is your doctor? \_\_\_\_\_ When was your last medical exam? \_\_\_\_\_

Health Status: Excellent Very good Good Average Poor

Please list present symptoms and/or medical conditions: \_\_\_\_\_

Are you currently being treated for these problems? Yes No

Who is treating you? \_\_\_\_\_

Please list any surgeries within the past 5 years: \_\_\_\_\_

Ever have a head injury or trauma? Yes No If yes, when? \_\_\_\_\_

Knocked unconscious? Yes No If yes, when? \_\_\_\_\_

If you sustained a head injury, were you treated? Yes No

Please list childhood illnesses, surgeries, handicaps, learning disabilities, etc.: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## SUBSTANCE USE

Do you smoke cigarettes? Yes No Previously

If yes, when did you start? \_\_\_\_\_ How much do you smoke? \_\_\_\_\_

Have you ever tried to quit? Yes No If yes, when was last attempt? \_\_\_\_\_

If you previously smoked, how long has it been since you quit? \_\_\_\_\_

Do you consume alcoholic beverages? Yes No If yes, age of first use? \_\_\_\_\_

Do you drink every day? Yes No If yes, how much? \_\_\_\_\_

If no, do you drink every week? Yes No If yes, how much? \_\_\_\_\_

When did you last consume alcoholic beverages? \_\_\_\_\_ How much? \_\_\_\_\_

Do you wake up sweaty, shaky, feeling sick and/or needing a drink? Yes No

Do you have hangovers? Yes No

What is the most you drink during drinking episodes? \_\_\_\_\_

What is the average amount you drink during drinking episodes? \_\_\_\_\_

Does anyone complain about your drinking? Yes No If yes, who? \_\_\_\_\_

Do you worry about your drinking? Yes No

Have you tried to stop? Yes No If yes, when was last attempt? \_\_\_\_\_

Do you use any other substance (i.e., cannabis, pain pills, meth, cocaine)? Yes No

If yes, please answer the following as accurately as possible:

Substance	When was last use?	Age at first use?	How much do you use each time?	How do you use this substance?

Have you ever been admitted to detox for any substance? Yes No

If yes, when? \_\_\_\_\_ What substance? \_\_\_\_\_

List any current or past legal problems because of your use of alcohol or other drugs:

\_\_\_\_\_

\_\_\_\_\_

Did your mother drink/drug when she was pregnant with you? Yes No Don't know

If yes, how do you know she did? \_\_\_\_\_

If you are pregnant, are you currently drinking or using other drugs? Yes No

If yes, what substances are you using? \_\_\_\_\_

How much are you using? \_\_\_\_\_ How often are you using? \_\_\_\_\_

Have you spoken to your doctor about your use? Yes No

### COUNSELING

List all previous counseling, psychotherapy, substance abuse/dependence treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List the problems you would you like to discuss:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In case of emergency, whom would you like us to notify? \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

**(please note, we will ask you to sign an Authorization for this person)**