Road 2 Resolutions PLLC
Professional Counseling

Adolescent Intake Form

Name: ____________________________________ Date of Birth:____________ Age:_________

Race: _____________________________________ Birthplace: ______________________________

Gender: Male ______ Female _______ Religion: _________________________ ______

Address: _______________________________City:______________ State: _______ Zip: ________

Home Phone: __________________________

Referred by: ____

Name of Parent/Legal Guardian: _________________________ Phone # __________________

Address: _______________________________City:______________ State: _______ Zip: ________

☐ Sole Custody ☐ Joint Custody

Marital status of the child's parents ____

Name ______________________ Phone # _____________ Relationship to client: _____________

Address: _______________________________City:______________ State: _______ Zip: ________

Emergency Contact Person: ___________________________________ Phone Number:_____________

Current Education Status:

School Attending ________________________ Grade ___________

Are there other children living at home? ____ Yes ____ No

If yes, please give names and ages. ____

____

For what purpose are you seeking treatment for this child?___________________________________

____

____

Has the child received counseling in the past? ___ Yes ___ No If yes, where? _________________

____

Please explain any current or past medical conditions: _______________________________________

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Please list any prescription medications the child is taking. __________________________________

____

To your knowledge has the child ever attempted suicide? _____ Yes _____ No If yes, please explain:

____

To your knowledge has the child been a victim of physical/emotional or sexual abuse? ☐ Yes ☐ No

If Yes, please explain: ____

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