

**Finding Center Counseling and Wellness Services**  
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**ADOLESCENT INTAKE FORM**  
**FOR PARENT TO COMPLETE**

*Hello and welcome. Thank you for taking the time to complete this form. The information is meant to help us start our time together in a meaningful way.*

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**PERSONAL INFORMATION**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parent's Name(s): \_\_\_\_\_

Primary Address: \_\_\_\_\_  
City State Zip

Phone #'s: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Ok to leave message? Yes / No Yes / No Yes / No

E-Mail: \_\_\_\_\_ Referral source: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Part / Full Time

Employer's Address: \_\_\_\_\_  
City State Zip

Child's Racial/Ethnic Identity: \_\_\_\_\_ Child's Gender Identity: \_\_\_\_\_

Child's Primary Care Physician: \_\_\_\_\_ ph: \_\_\_\_\_

Child's School: \_\_\_\_\_ grade: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ ph: \_\_\_\_\_

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**CURRENT REASON FOR SEEKING COUNSELING**

Briefly describe what you identify as the primary concerns/struggles: \_\_\_\_\_

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What would you like to happen as a result of counseling? \_\_\_\_\_

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**PAST EXPERIENCE WITH COUNSELING**

Experience with therapy (when, how long, with whom): \_\_\_\_\_

\_\_\_\_\_

What was most helpful? \_\_\_\_\_

\_\_\_\_\_

Was anything unhelpful? \_\_\_\_\_

\_\_\_\_\_

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**ADOLESCENT'S PERSONAL STRENGTHS**

What gifts and talents does your child have? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What activities does your child enjoy and participate in? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your family have a spiritual or religious belief that is meaningful in your lives? If so, please describe:

\_\_\_\_\_

\_\_\_\_\_

What other strengths do you see in your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**EDUCATION**

What school does your child attend? \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher's name: \_\_\_\_\_

What does your child's teacher say about them? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you connected with the school counselor?  Yes  No If yes, was it helpful?  Yes  No

School Counselor's Name: \_\_\_\_\_

Have your child ever repeated a grade:  Yes  No If so, which one(s)? \_\_\_\_\_

Has your child ever received special education services?  Yes  No

If yes, last IEP date: \_\_\_\_\_ IEP Case Manager: \_\_\_\_\_

Main Goals of IEP: \_\_\_\_\_

\_\_\_\_\_

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### **ADOLESCENT'S DEVELOPMENT**

Were there any complications with the pregnancy or birth of your child?  Yes  No

If yes, describe: \_\_\_\_\_

\_\_\_\_\_

Did your child have any health problems at birth?  Yes  No

If yes, describe: \_\_\_\_\_

\_\_\_\_\_

Has your child experienced any emotional, physical or sexual abuse?  Yes  No

If yes, describe: \_\_\_\_\_

\_\_\_\_\_

Has your child experienced any trauma?  Yes  No

If yes, describe: \_\_\_\_\_

\_\_\_\_\_

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### **FAMILY HISTORY**

Parents' Marital Status:

Single  Involved  Living Together  Married  Divorced  Separated  Widowed

Length of marriage/relationship: \_\_\_\_\_ If divorced, child's age at time of divorce: \_\_\_\_\_

If divorced, how much time does your child spend with each parent: \_\_\_\_\_

\_\_\_\_\_

Family Members/Others Living in Parent 1's Home:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Family Members/Others Living in Parent 2's Home:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_

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**FAMILY CONCERNS**

✓ *Check if your family is currently experiencing* ✓

<input type="checkbox"/>	Fighting	<input type="checkbox"/>	Disagreeing about relatives
<input type="checkbox"/>	Feeling distant	<input type="checkbox"/>	Disagreeing about friends
<input type="checkbox"/>	Loss of fun	<input type="checkbox"/>	Alcohol use
<input type="checkbox"/>	Lack of honesty	<input type="checkbox"/>	Drug use
<input type="checkbox"/>	Physical fights	<input type="checkbox"/>	Feeling unsafe
<input type="checkbox"/>	School problems	<input type="checkbox"/>	Divorce/separation
<input type="checkbox"/>	Financial problems	<input type="checkbox"/>	Issues regarding remarriage
<input type="checkbox"/>	Death of a family member	<input type="checkbox"/>	Birth of a sibling
<input type="checkbox"/>	Abuse/neglect	<input type="checkbox"/>	Birth of a child
<input type="checkbox"/>	Inadequate housing	<input type="checkbox"/>	Inadequate health insurance
<input type="checkbox"/>	Adult is unemployed	<input type="checkbox"/>	Addiction
<input type="checkbox"/>	Disrespecting each other	<input type="checkbox"/>	Other...

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Is there anything else you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_