KATHLEEN RAPP, LCSW
ADOLESCENT INTAKE FORM

Teen's Name ________________________________ SSN ________________________ Today's Date _____________
Birth Date ______ Age _____ Gender M ❑ F ❑ E-mail ______________________ Cell ____________________
Grade in School _________ School of Attendance ______________________________ Religion ____________________
Primary Care Physician ______________________________________ Phone ________________ Fax _____________

Parents Information: Teen lives with ___________

Mother's Name _____________________________________ Father's Name _____________________________________
Address ____ Address ____
City, State Zip _____________________________________ City, State, Zip ___________________________________
Home Ph. ________________ Cell Ph. _________________ Home Ph. ________________ Cell Ph. ________________
Occupation ___________ E-mail _____________________ Occupation ___________ E-mail _____________________

Insurance Information:
Insurance Co. ________________________ Subscriber ID ________________ Subscriber Name ____________________
Employer ____________________________ Address ________________________________ Subscriber DOB ___________
How did you hear about this practice? ____

List of siblings:

Sibling's name	Age	Lives where	Useful information about your sibling

If you have you ever been treated for a *mental health issue (including substance abuse)*, please complete the following:

Date(s)	Counselor/Hospital	Focus of Treatment	Reason for Stopping

List of *current medications* (include supplements):

Medication	Dosage	Date Started	Medication	Dosage	Date Started

List of *medical conditions, handicaps, surgeries, accidents or suicide attempts*:

Date	Condition/Experience	Details	Current Status

For each problem/issue listed that you experience, place a check mark in the appropriate column to indicate *how often you/your child experiences the problem or issue*. Include problems/issues that apply even if you/your child don't intend to work on them in therapy.

	--------------- FREQUENCY ---------------		
Problem/Issue	**None/little of the time**	**Some of the time**	**Most or all of the time**
Wake at night or early morning and unable to return to sleep			
Very restless sleep			
Unable to fall asleep			
Sleeps a lot			
Bad dreams or nightmares			
Fatigue or lack of energy			
Unable to enjoy life; has lost zest for life			
Has withdrawn from others			
Feeling isolated and lonely			
Lack of motivation			
Feelings of inferiority			
Loss of appetite			
Thoughts of hurting self/episode(s) of self-harm			
Thoughts of suicide			
Thoughts of hurting someone else			
Personal or family violence			
Loss of appetite			
Memory problems; forgetfulness; inability to concentrate			
Irritable or easily frustrated			
Sadness or hopelessness			
Increased energy			
So happy or energetic that people say he/she is “hyper” or “manic”			
Decreased need for sleep			
Sudden episodes of nervousness or panic			
Fear of losing self-control			
Palpitations or rapid heartbeat			
Shortness of breath			
Tense and anxious all day			
Very anxious in social situations			
Recurring troubling thoughts, images or impulses			
Repetitive behaviors (such as hand-washing, checking, ordering)			
Obsessive thinking/questioning			
Very confused, strange or bizarre thoughts			
Hallucinations, hearing voices, seeing things that aren't really there			
Very peculiar experiences that others do not understand			
Oppositional/defiant behavior			
Angry outbursts			
Feel like you're ready to explode			
Runs away/leaves home without permission			
Use of drugs or alcohol			
Use of pornography			
Overeating			
Anorexia and/or bulimia			

For each item listed, place a check mark in the appropriate column to indicate how often you/your child are involved with each of the following:

----------------------- FREQUENCY -----------------------

Involvement	Never	Rarely	Sometimes	Often	Always
Getting together with friends					
Family activities					
Church/temple activities					
Clubs and organizations					
Sports/Exercise					
Yoga					
Meditation					

Please describe any past or present challenges with the following:

Issue	Description of Challenges
School	
Parents	
Siblings	
Friendships/ Social life	
Relationships	
Legal	
Child neglect/abuse	

Is/was school difficult for you/your child? Yes ❑ No❑ If yes, please describe___________________________________

How well do your parents get along with each other? ____

How well do you get along with your parents? ____

If there is anything else you would like me to know or you think might help our work together, please include it here:

____

____

The information in this document will remain confidential. Providing this information is voluntary.

By signing below, I/we hereby consent to treatment with Kathleen Rapp, LCSW.

Teen's Signature ____ Date ____________________

Parent's Signature ____ Date ____________________