Date: _____

Awakened Awareness, LLC

Adolescent Intake (For the client to complete)

Last Name	First Name	Middle Initial	Preferred Name
Race	Primary Language	Date of Birth	Age
Legal Sex	Gender Identity	Preferred Pronouns	Sexual Orientation
Street Address			
City	State		Zip Code

☐ Home Phone ☐ Cell Phone ☐ Email Address
(please check preferred method of contact)

Is it ok to leave messages? ☐ Yes ☐ No

Whose idea was it for you to come to counseling? _____

How do you feel about being here? _____

What event(s) or problems have resulted in you coming for counseling? _____
_____
_____
_____

Have you been in counseling before? ☐ Yes ☐ No
If so, was it helpful? Why or why not? _____
_____

What school do you go to? _____ Grade: _____

What activities are you in at school, if any? (sports, music, etc.) _____

_____

_____

What do you like most about school? _____

What do you like least about school? _____

Have you ever been a victim of bullying? ☐ Yes ☐ No

How? ☐ In-Person ☐ Online ☐ Texts/Calls

If yes, how often and when was the last time? _____

_____

<u>How often do you (Check any that apply):</u>

Drink alcohol	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Smoke cigarettes	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Smoke marijuana	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Other: _____	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Other: _____	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily

<u>Check any that apply to you:</u>

☐ Headaches once a week or more

☐ Gained/lost 10+ pounds in the past 2 months

☐ Difficulty falling asleep

☐ Wake up a lot during the night

☐ Wake up very early, then can't get back to sleep

☐ Have a hard time concentrating

☐ My memory is not as good as it used to be

☐ Have thoughts that trouble me sometimes

☐ My behavior scares me sometimes

Are you currently having thoughts of suicide? ☐ Yes ☐ No

Are you currently having thoughts of homicide? ☐ Yes ☐ No

Have you attempted suicide in the past? ☐ Yes ☐ No

If so, How many times? _____ When?

_____

Have you intentionally burned, cut, or hurt yourself? ☐ Yes ☐ No

If yes, what do you do? _____

How often? _____ When was the last time? _____

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

Describe your family: _____
_____
_____

What are your personal strengths? _____
_____
_____

What are your goals for therapy? _____
_____
_____

Current major stressors in your life: _____
_____
_____
_____

Who is your biggest support/somebody you can talk to? _____

What are your dreams for the future? _____
_____
_____

Please list any major changes in your life over the past five years (moving, parents' divorce, etc.): _____
_____
_____

Anything else you want me to know about you? _____
_____
_____
_____
_____

I certify that the above information is true and correct to the best of my knowledge.

Signature of Client Date