DEANDA SYLTE ROBERTS

M.A.

ADOLESCENT COUNSELING INTAKE FORM (AGES 12-17)

DATE

PERSONAL INFORMATION

FULL LEGAL NAME

DATE OF BIRTH

WHAT YOU LIKE TO BE CALLED

AGE

SSN

STREET ADDRESS

CITY

STATE

ZIP

Yes
No
OKAY TO MAIL?

EMAIL

Yes
No
OKAY TO EMAIL?

HOME PHONE

Yes
No
OKAY TO CALL?

CELL PHONE

Yes
No
OKAY TO CALL/TEXT?

EMERGENCY CONTACT NAME & PHONE

EMERGENCY CONTACT RELATION TO YOU

REFERRAL SOURCE TO COUNSELING

Please briefly describe the reason you are seeking counseling services and what goals you hope to achieve in therapy:

705 W. Seventh Ave, Ste. 1-C Spokane, WA 99204

DR

(509) 624-7252 • sylteroberts@comcast.net

PERSONAL INFORMATION

Please answer the following questions by circling: 5 – Excellent, 4 – Good, 3 – Average, 2 – Poor, 1 – Failing

How would you currently rate your physical health?	1	2	3	4	5
How would you currently rate your mental health?	1	2	3	4	5
If applicable, how would you currently rate your spiritual health?	1	2	3	4	5

Please briefly describe any faith practice you engage in and/or faith community you are a part of:

Do you hope to incorporate faith/spirituality into your counseling process? If yes, please describe how you would like to do so:

PRIMARY CARE PROVIDER

ADDRESS

PHONE

Are you currently under the care of a specialist physician? If yes, please list the following:

SPECIALIST PHYSICIAN NAME

ADDRESS

PHONE

Have you ever or are you currently experiencing difficulties with any of the following health concerns? Please check all that apply:

Asthma		Fibromyalgia		Vision problems	
Allergies		Heart disease		Hearing problems	
Brain Injury		Thyroid disorder		Diabetes	
Digestive concerns		Hearing problems		Seizures	
Respiratory concerns		Multiple sclerosis		Cancer	
High blood pressure		Epilepsy		Headaches	
High cholesterol		Autoimmune complications		Tuberculosis	
Chronic fatigue		Sleep disturbance		Weight Change	
Chronic pain		Sexually transmitted disease		Other	

Please briefly explain any check marks above (date, severity of symptoms, current status, etc.):

Please list any prescription medications you are currently taking, including dosage information:

Please list any over the counter medications, vitamins, or supplements you are currently taking, including dosage information:

Are you currently or have you ever been pregnant? _____

NUMBER OF LIVE BIRTHS

NUMBER OF MISCARRIAGES

NUMBER OF ABORTIONS

NUMBER OF ADOPTIVE PLACEMENTS

Please list and provide the approximate date(s) of any surgeries you have had or serious accidents you have experienced:

MENTAL HEALTH HISTORY

Are you currently (in the past 6 months) experiencing the following? Please check all that apply:

Feeling more sad than normal		Mood swings	
Worrying more than normal		Obsessive and/or racing thoughts	
Social anxiety		Impulsivity/making decisions you later regret	
Critical thoughts about self		Thoughts of self harm and/or suicide	
Feelings of hopelessness		Restlessness and/or irritability	
Increase in conflict with parent(s)		Nightmares/difficulty sleeping	
Increase in conflict with peer(s)		Feeling more angry than normal	

Are you currently or have you ever been in counseling/therapy before? _____ If yes, please briefly describe your experience (approximate dates and duration of previous counseling, name of practitioner, type of counseling, effectiveness, etc.):

Have you ever been hospitalized for mental health concerns? _____ If yes, please list hospital(s) and length/date(s) of stay:

Have you ever engaged or are you currently engaging in self harm? _____ If yes, please list approximate dates and methods used:

Have you ever contemplated or are you currently contemplating suicide? _____ If yes, please list approximate dates and describe nature of contemplation:

Have you ever attempted suicide? _____ If yes, please list date(s), methods used, and any subsequent treatment received:

Have you ever or are you currently contemplating harming another person? _____ If yes, please explain:

Has anyone in your family or anyone close to you attempted and/or completed suicide? _____ If yes, please explain (person(s), relationship to you, date(s), method(s) used, etc.):

Please indicate substances you use currently (in the past 6 months) or have used in the past, along with amount and frequency of use and age you began using substance:

Substance	Current	Past	Amount/Frequency	Age at first use
Caffeine				
Alcohol				
Tobacco				
Marijuana				
Crack/Cocaine				
Ecstasy				
Heroin				
Methamphetamines				
Sleep medications				
PCP/LSD/Mushrooms				
Pain killers				
Steroids				
Prescription Meds (not prescribed to you)				
Other				

Do you believe your current substance use is problematic?

Has anyone else ever expressed concern about your substance use?

Have you ever experienced problems with relationships, work, health, the law, etc. due to your substance use?
_____ If yes, please explain:

Have you ever participated in drug or alcohol treatment? _____ If yes, please list date(s) location,length, and type of treatment:

FAMILY & RELATIONSHIP HISTORY

Please list the names, ages, and nature of relationship for each person with whom you currently live:

Name	Age	Nature of Relationship

Please describe the experiences with/aspects of your family that you most enjoy:

Please describe the experiences with/aspects of your family that you least enjoy:

Were you adopted? _____ If yes, please list your age at time of adoption: _____

Were your parents married? _____ Divorced? _____ If divorced, your age at separation: _____

Please indicate whether you or an immediate family member experienced any of the following:

Event	Self	Other	Relation to you
Emotional abuse			
Physical abuse			
Physical/domestic abuse			
Substance abuse			
Neglect			
Serious illness/accident/injury			
Financial problems			
Frequent/multiple moves			
Legal problems			
Racial/ethnic discrimination			
Discrimination based on sexual preference/gender identification			
Marital infidelity			
Homelessness			
Other:			

EDUCATION/VOCATIONAL HISTORY

Are you currently in school? _____ If yes, which school do you attend? _____

Are you currently employed? _____ If yes, please list name of employer, type of work, and length of time at current place of employment:

Please list your personal hobbies or interests:

Please list any peers you currently spend a significant amount of time with:

Are you currently in a romantic relationship? _____ If yes, please list name of person, relationship status, and length of time you have been together:

Please describe your sexual orientation, gender identity/expression, and preferred pronoun(s):

Please answer the following questions by circling:

5 – Very Satisfied, 4 – Satisfied, 3 – Somewhat Satisfied, 2 – Somewhat Dissatisfied, 1 – Not at all Satisfied

How satisfied are you currently with your family relationships?	1	2	3	4	5
How satisfied are you with your current group of friends and/or support system?	1	2	3	4	5
How satisfied are you with your involvement in extracurricular activities/hobbies?	1	2	3	4	5
How satisfied are you with your grades/academic performance?	1	2	3	4	5

LEGAL HISTORY

Have you ever been the victim of a crime? _____ If yes, please briefly describe:

Have you ever been convicted of a misdemeanor or felony? _____ If yes, please explain:

Are you currently involved in divorce, child custody, or other legal proceedings? _____ If yes, please explain:

ADDITIONAL INFORMATION

Is there anything else you would like me to know about you prior to the start of therapy that would be helpful in discerning the best course of treatment?

***Note: I believe protecting your privacy is essential to a safe and effective counseling relationship. In the state of Washington, minors ages 13 and older are legally entitled to receive confidential outpatient counseling services without the consent of a parent. I am legally required to break confidentiality in the event you report intent to harm yourself or another person; in addition, I am legally required to report any knowledge I have of abuse or neglect of a minor. Aside from these legal requirements, the information you share with me will be kept strictly confidential, even from your parent(s) unless you consent to sharing that information.*