Joelle Jacobson, M.A., M.F.T., P.P.S.
Teen Talk Line
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TeenTalkLine (SKYPE)
855 – 833 - 6411 (fax)

OFFICE USE ONLY

Dx Name:

Dx Number:

ADOLESCENT INTAKE FORM

Name:_____ Date:_____

Primary Address:_____
Street City Zip Code

Birth Date:_____ School:_____

Grade:_____

Guidance Counselor:_____

Mother:_____ Occupation:_____

Address: _____

Home Phone #:_____ **E-Mail Address**:_____

Cell Phone #:_____ Work Phone # :_____

Father:_____ Occupation:_____

Address:_____

Home Phone #:_____ **E-Mail Address**:_____

Cell Phone #:_____ Work Phone #:_____

Previous Therapy:_____
Therapist's Name Period of Time Therapy Issue

Physician:_____ Phone:_____

Date of your last physical? Blood work? _____

Please describe your living arrangements (with whom, time split, etc.) and list other children in the home(s): _____

_____ _____
Name Age Relationship Name Age Relationship

In case of emergency, please notify:_____

Relationship: _____

Phone:_____

Why are you seeking counseling at this time? _____

_____

_____

_____

Check any symptoms you may have exhibited in the past six months:

___ Sadness/Crying Spells
___ Socially Isolated
___ Weight Loss or Gain
___ Insomnia
___ Excessive Sleep
___ Loss of interest
___ Difficulty Having Fun
___ Excessive Anger/Hostility
___ Suicidal Thoughts/Statements
___ Difficulty with Authority Figures
___ Often in Trouble
___ Argumentative
___ Alcohol and other drug use
___ Change in friends
___ Other (please describe): _____

___ Nervousness/Jittery
___ Irritable/Temper Outbursts
___ Persistent Thoughts
___ Mood Swings
___ Excessive Worrying
___ Fidgety
___ Nightmares
___ Feeling like you are out of control
___ Grieving
___ Easily Distracted
___ Conflicts with Peers
___ Risk taking behavior
___ Self-injury
___ Change in grades

Have you ever been hospitalized? If so,why?

_____

_____

_____

List and describe any history of emotional disorder(s) in your biological family

(e.g.; addiction, depression, schizophrenia etc.):

_____

_____

_____

List and describe any significant life events (e.g. divorce, death in family, break-up etc.):

_____

_____

_____

How are you doing in school (i.e. grades, with peers, with teachers, with coaches)?

_____

_____

List and describe any current or historical physical problems (e.g. weight gain, headaches, stomach aches, etc.):

_____

_____

_____

List any medication(s) and dosage you are currently prescribed: _____

_____

_____

_____

Prescribing Physician: _____ Phone: _____

Consent to speak to physician: _____ _____

Name Date

What are your strengths and hobbies? _____

_____

_____

List your three primary treatment goals:

1. _____
2. _____
3. _____

How did you hear about Teen Talk Line?_____

It is customary to thank the referring person. **Your signature below gives me permission to contact and thank this person (optional)**. No other information will be disclosed.

Signature:_____ Date:_____

Revised 4/2011
