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ADOLESCENT INTAKE FORM
AUTHENTICALLY ME PSYCHOTHERAPY, LLC

(Please provide as much detail as possible, we will review this together during our first session)

Name: _____ Gender (birth & preferred): _____

Intake Date: _____ Age: _____ Date of Birth: _____

E-mail: _____ Phone: _____

Mailing Address *(where you live. Please note that you must live in PA in order for me to provide you clinical services):*

Parent/Guardian E-mail: _____ Okay to e-mail? Y N

Parent/Guardian Phone: _____ Okay to call? Y N Text? Y N Voice message? Y N

Client E-mail: _____ Okay to e-mail? Y N

Client Phone: _____ Okay to call? Y N Text? Y N Voice message? Y N

Relationship Status: _____ Partner(s): _____

Sexual Orientation/ Who are you attracted to? _____

What issue(s) brings you in today?

In the past 6 months, have you experienced any of the following (check off all applicable spaces):

- | | | |
|---|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of interest |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Guilt | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Other. Describe: |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Impulsivity | |
| <input type="checkbox"/> Excessive Energy | <input type="checkbox"/> Irritability | |

Share more information about the areas you just checked off on the prior page: _____

Describe what your sleeping habits or challenges are like: _____

Are there certain persons, places or things you have been avoiding that are impacting your daily functioning? If yes, please explain _____

Are you sexually active? Y N

Does your parent/legal guardian know? Y N

Is there currently, or has there ever been, an important person in your life that regularly puts you down? If yes, please explain _____

Previous therapy/treatment (please describe what type and if it was/wasn't helpful):

What has helped to manage the current issues?

What makes the current issues worse?

What are your strengths and interests? _____

What makes you feel happy? _____

Religious/Spiritual Affiliation (share if your religion/spiritual beliefs are different from your family's): _____

Any head, neck or jaw pain or head/neck injuries (*concussions, ear pain, TMJ, etc.*):

Medical conditions (share if you're being treated for any):

Would you like me to be able to connect with other professionals, to more holistically support you? Communication would only be done with your knowledge and consent. Please identify which other professionals you'd like me to communicate with:

PCP: _____ #: _____

OBGYN: _____ #: _____

Dentist: _____ #: _____

School: _____ #: _____

Court/JPO: _____ #: _____

Lawyer: _____ #: _____

Therapist: _____ #: _____

Psychiatrist: _____ #: _____

Specialist: _____ #: _____

Specialist: _____ #: _____

Other: _____ #: _____

Current Medications or Supplements (share if you are taking them regularly):

Medications in past: _____
(reason for discontinuing): _____

Any previous mental health diagnosis: _____

Eating difficulties and/or eating habits: _____

How often do you drink water? _____ Caffeine? _____ Alcohol? _____

Describe your physical movement routine? (i.e. sit at desk all day, work out weekly, daily walks) _____

Describe your overall health: _____

Sleeping difficulties and/or sleeping habits: _____

Do you often crave or dislike physical touch or body pressure? _____

Are there certain sounds, smells or textures that bother you or comfort you? _____

Sexuality-related challenges (i.e. heightened arousal, inability to engage sexually, fear of sexual engagement):

What is your relationship like with your parents/guardians/care givers:

Any family issues you want me to know about up front?

Have you experienced neglect, abuse or trauma?

Risk taking behaviors (i.e. stealing, putting self in dangerous situations on purpose):

Do you sometimes or often (*circle one*) lose chunks of time (*describe*): _____

Do you sometimes or often (*circle one*) dissociate or feel separate from body (*describe*): _____

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Please Circle yes or no.

		List Family Member
Alcohol/Substance Abuse	yes / no	_____
Anxiety	yes / no	_____
Depression	yes / no	_____
Domestic Violence	yes / no	_____
Eating Disorders	yes / no	_____
Obsessive Compulsive Behavior	yes / no	_____
Schizophrenia	yes / no	_____
Suicide Attempts	yes / no	_____
Bipolar Disorder	yes / no	_____
Other		_____

History of suicide attempt or ideation: _____

Currently suicidal: _____

******If you are actively struggling with wanting to kill yourself, please stop completing this form and immediately reach out to 9-1-1 or a trusted adult that can take you to a crisis center to receive the necessary acute care to become stabilized. Authentically Me Psychotherapy, LLC is not a crisis center and cannot provide acute care.******

History of self-harm: _____

Currently self-harming: _____

If you answered yes to any suicide or self-harm questions, are you willing to commit to a goal of safety with and for yourself, during our time together, while we work on strengthening your ability to create and maintain relationships with yourself and others that feel safe, trusting and comforting?

YES or NO (*circle one*)

What are your primary goals in coming to therapy at this time? In other words, how would you know that treatment has been helpful for you? _____

How did you discover Authentically Me Psychotherapy, LLC/Dr. Toni: _____

Anything else you want me to know before we start working together?

***YOU HAVE TAKEN A COURAGEOUS STEP BY CHOOSING THERAPY.
YOU ARE ALREADY ON YOUR WAY TO PROGRESS!***