uFringo Counseling LLC

ADOLESCENT COUNSELING INTAKE FORM

Client Information

Client Name_____
Date of Birth_____Preferred Pronouns_____
School_____ Grade_____
Address_____
Home Phone_____ Work Phone_____
Cell Phone_____e-mail_____

Parent/Guardian Information

Name(s)_____
Address (If different from client's address)_____
_____
Mom Home Phone_____ Dad Home Phone_____
Mom Work Phone_____ Dad Work Phone_____
Mom Cell Phone_____ Dad Cell Phone_____
Mom e-mail _____ Dad e-mail _____

Emergency Contact Information

Name _____
Address_____
Home Phone_____ Work Phone_____
Cell Phone_____e-mail _____

Sibling Information

Please list all siblings, their ages, and whether they live at home:

_____
_____

How did you hear about uFringo Counseling?

_____

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Clinical Information

(For individual counseling, client should complete this section confidentially. For family counseling, each family member should complete a copy of this section.)

What are your reasons for coming to counseling at this time?

What are your strengths, what are you good at?

What do you like to do in your free time?

What do you and your friends do when you hang out together?

Are you currently taking any medication? If yes list medication, dose, and name of prescribing physician:

Have you ever been hospitalized for physical illness or surgery? Yes No
If Yes, please describe:

Have you ever been hospitalized for mental illness? Yes No
If Yes, please describe:

Have you received psychological help of any kind in the past? Yes No

Is there anyone you think I should talk to in order to help you better? (e.g. School Psychologist, Pediatrician, Coach, Youth Group Leader) Yes No
If Yes, please list their name (s) and role(s) in your life. Also please complete a Consent to Release Information Form.
Name_____ Role_____

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Please circle any and all characteristics you recognize might be causing you trouble now or in the recent past:

Anxiety or Worries	Disruptive Behavior	Poor Concentration	Unhappiness	Social Isolation
Shyness	Suspiciousness	Headaches	School Performance	Chronic Pain
Drug Use	Too Much Energy	School Behavior	Making Decisions	Divorce, Separation
Anger	Troublesome Thoughts	Insomnia	Stress	Friendship Troubles
Nightmares	Recurrent Thoughts	Binge Eating	Health Problems	Guilt
Relationship Issues	Problems with Authority	Low Self Esteem	Adoption and/or Attachment	Lack of Assertiveness
Sadness	Relationship w/Parents	Weight Control	Hyperactivity	Post Traumatic Stress
Fatigue or Tiredness	Depression	Grief	Anger	Self-Injury, Cutting
Loneliness	Sexuality	Abuse	Appetite	Sexual Harassment
School Avoidance	Alcohol Use	Mood Swings	Body Image	Lesbian, Gay,Bi Related Concerns
Sibling Relationships	Housing Problems	Fears	Impulsivity	Transgender, Non-Binary Related Concerns:
Addiction	Self-Control	Suicidal Thoughts	Anorexia/Bulimia	Other:

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Have you ever thought about suicide?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever gotten so mad at someone that you wanted to hurt them?	Yes	No
Have you ever attempted to harm others in the past?	Yes	No

Thank you for completing this form.