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Please note that this information is important for your child's care. Please fill out forms as completely as possible and have them ready before the first appointment. You may scan and email the completed form directly to Dr. Wetter at drwetter@drwetter.com

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescent's Name: _____

Date of Birth: _____ Age: _____ ❒ Male ❒ Female

Race/Ethnic Origin: _____

Religious Preference:

_____

Name **CURRENT HOUSEHOLD AND FAMILY INFORMATION**	Relationship (parent, sibling, etc)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(If additional space is need please list on the back of page)

Current Reason For Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

_____

_____

What would you like to see happen as a result of counseling? _____

_____

What is most concerning right now? _____

_____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe: _____
2. Did your child have health problems at birth? Yes _____ No _____
   If yes, describe: _____
3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)?
   Yes ___ No ___ Not sure_____
   If yes, describe: _____
4. Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___
   Not sure_____ If yes, describe: _____
5. Has your child experienced emotional, physical, or sexual abuse?
   Yes ____ No ____ Not sure _____ If yes, describe: _____

COUNSELING HISTORY

Have your son or daughter previously seen a counselor? ❒ Yes ❒ No

If Yes, where: _____

Approximate Dates of Counseling: _____

For what reason did your son or daughter go to counseling? _____

Does your son or daughter have a previous mental health diagnosis? _____

What did you find **most helpful** in therapy? _____

_____

What did you find **least helpful** in therapy? _____

_____

Has your son or daughter used psychiatric services? Yes____ No____

If yes, who did they see? _____

If yes, was it helpful? N/A____ Yes____ No_____

Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Name of medication	Dates taken	Was it helpful? (Y/N)

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____

If so, please describe. _____

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____

If yes, please explain your concern: _____

_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc? (Y/N) _____

If yes, please explain your concern: _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, at present, or have had a significant effect upon you or your son or daughter in the past. _____

_____

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3? _____

_____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable. _____

_____

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)? _____

_____

PARENT'S MARITAL STATUS *(this question refers to the biological parents relationship)*

❒Single ❒Married (legally) ❒Divorced ❒Cohabitating ❒Divorce in process ❒Separated ❒Widowed ___Other

Length of marriage/relationship:_____ If divorced, how old was your child at time of divorce? _____

If divorced, How much time does your child spend with each parent? Mother_____%, Father _____%

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent.)

Mother/Father's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

Please answer if you are no longer with your child's bio-mother* **OR *check here if you are still with bio-mother*_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Mother/Father's Name: _____Birth Date:_____ Age: _____

Ethnic Origin: _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current Status _____Single, ____Married, ____Divorced, ____Separated, _____Widowed, _____Other

Please answer if you are no longer with your child's bio-father* **OR *check here if you are still with bio-father*_____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

FAMILY CONCERNS

Please check any family concerns that your family is currently experiencing.

	fighting		Disagreeing about relatives
	feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity (couple)
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Birth of a child
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Other

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try? _____

_____

What personal qualities would you say your son or daughter has? _____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe) _____

_____

INDIVIDUAL CONCERNS YOU NOTICE REGARDING YOUR SON OR DAUGHTER

SYMPTOM	NONE	MILD	MOD	SEVERE	SYMPTOM	NONE	MILD	MOD	SEVERE
SADNESS					APPETITE CHANGES				
CRYING					WEIGHT CHANGES (UNPLANNED CHANGES)				
SLEEP DISTRUBANCES					PARANOID THOUGHTS				
DISSOCIATION					POOR CONCENTRATION				
HYPERACTIVITY					INDECISIVENESS				
BINGING/PURGING					LOW ENERGY				
DECREASED SEX DRIVE					EXCESSIVE WORRRY				
UNRESOLVED GUILT					LOW SELF WORTH				
IRRITABILITY					ANGER ISSUES				
NAUSEA/ INDIGESTION					SPIRITUAL CONCERNS				
SOCIAL ANXIETY					HALLUCINATIONS				
SELF MUTALATION					RACING THOUGHTS				
CUTTING					RESTLESSNESS				
IMPULSIVITY					DRUG USE				
NIGHTMARES					ALCOHOL USE				
HOPELESSNESS					DECREASED CREATIVITY				
ELEVATED MOOD					EASILY DISTRACTED				
MOOD SWINGS					TRAUMA FLASHBACKS				
DISORGANIZED					WORK ISSUES				
ANOREXIA					PROBLEMS AT HOME				
SOCIAL ISOLATION					PANIC ATTACKS				
PHOBIAS					FEELING ANXIOUS				
OBSESSIVE THOUGHTS					FEELING PANICKY				
GRIEF					SUICIDAL THOUGHTS				
HEADACHES					PAST SUICIDE ATTEMPTS				
LONELINESS					OTHER				

Is there anything else you would like to share: _____

_____

_____