LifeCare Counseling
Psychotherapy Services Caring for You and Your Life

CLIENT INTAKE FORM

Adolescent-Biopsychosocial History

1293 Professional Drive, Suite A-101
Myrtle Beach, SC 29577
843.605.0514 office 843.962.5570 fax
info@mylifecarecounseling.com

CLIENT INFORMATION

Client Name *(Last, First, M.I.):* ☐ M ☐ F		Date of Birth:
Address:		
City:	State:	Zip:
Email:		
Phone: (H)	Cell:	
School:	Grade:	

PARENT/GUARDIAN INFORMATION

Parent/Guardian *(Last, First, M.I.):* ☐ M ☐ F			Date of Birth:
Address:			
City:	State:		Zip:
Email:	Preferred Contact Method: ☐ Y ☐ N		
Phone: (H)	(W)		(Cell)
Employer:	Occupation:		
Parent/Guardian-Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Spouse/Partner Name:	☐ M ☐ F	Age:	Date of Birth:
HOUSEHOLD INFORMATION: Please list family members.	Sex	Age	Relationship (i.e., parent/sibling, etc.)
Name:	☐ M ☐ F		
Name:	☐ M ☐ F		
Name:	☐ M ☐ F		
Name:	☐ M ☐ F		
Name:	☐ M ☐ F		
Name:	☐ M ☐ F		

INSURANCE INFORMATION

Do you have insurance?		☐ Yes ☐ No	
Primary Insurance Provider:		Type of Insurance Plan:	
Subscriber's name:			Birth date:
Policy/ID #:		Group #:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Subscriber's Occupation:		Employer:	
Employer address:			Employer phone:

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Presenting Problem/Concerns

What problems/concerns bring (adolescent) client in for counseling?

History of presenting problem:

1. When did symptoms/problems occur?
2. How often does the problem occur?
3. What has been helpful in reducing symptoms/problems?

What changes/improvements do you hope to be made as a result of counseling?

Has your Adolescent been in Counseling previously? ☐ Yes ☐ No

If yes, please provide details (i.e., Counselor Name, Length of Counseling, Counseling Outcome-beneficial/not helpful).

Has your Adolescent been hospitalized for mental health reasons? ☐ Yes ☐ No

If yes, please provide details (i.e., Facility Name, Length of Treatment, Results (i.e., beneficial/not helpful, etc.).

Client's Strengths & Growth Areas:

Describe client's strengths (i.e., caring, good student, etc.):

Describe client's growth areas (i.e., improved motivation, respectful behavior, etc.):

Describe client's personality/temperament (i.e., anxious, easy going, quiet, etc.):

Family Strengths & Growth Areas:

Describe family strengths (i.e., supportive, good structure, etc.):

Describe family growth areas (i.e., more quality time, better communication, etc.):

Describe your relationship with client (i.e., good, strained, conflicted, etc.)

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Substance Use History

Nicotine Use (vapes, Juul, tobacco)	☐ Current	☐ Suspected	☐ Past	☐ No
Alcohol Use	☐ Current	☐ Suspected	☐ Past	☐ No
Drug Use	☐ Current	☐ Suspected	☐ Past	☐ No

* If any answer YES, please explain type, pattern of use, and any consequences of use (i.e., school, legal, etc.):

Medical History

Does client have a Primary Care Provider ☐ Yes ☐ No

If so, please provide Medical Provider Name/Location and approximately how long client has been a patient of PCP.

Is client taking any medications (Please also include any over-the-counter medications) ☐ Yes ☐ No
If yes, please list below:

Medication	Dosage	Reason

Please describe client's medical history and include any major medical problems, injuries, surgeries.

Does client have any allergies? ☐ Yes ☐ No If yes, please list:

Developmental History

Were there any problems with the pregnancy or delivery?	☐ Yes	☐ No
Did client experience any difficulties or delays in walking, talking, or toilet training?	☐ Yes	☐ No
Were there any childhood injuries impacting development?	☐ Yes	☐ No
Did client experience any developmental delays impacting cognition, learning, processing?	☐ Yes	☐ No
Did client experience any emotional/behavioral difficulties as a child?	☐ Yes	☐ No

If yes to any above, please explain:

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School History

Current School: _____ Grade Level: _____

Please provide a brief description of client's current academic performance:

Please provide a brief description of client's past academic performance:

Does or has client ever had an IEP or 504 plan?

Has client ever had behavioral problems in school?

Has client experienced bullying and/or situations that cause he or she to avoid/not participate or have high anxiety?

Please describe client's peer supports (i.e., close friends, school activities, etc.).

Please share any other school-related information you think would be helpful?

CLIENT SYMPTOMS/CONCERNS: Check & rate any applicable symptoms/concerns below.

Client Symptoms/Concerns	Mild	Moderate	Severe		Mild	Moderate	Severe
Sadness/Crying				Self-injury (cutting, other self-harm behaviors, etc.)			
Sleep Disturbances (insomnia, erratic sleep, sleep too much)				Suicidal Thoughts			
Appetite Changes				Suicidal Attempts			
Weight Gain/Loss				High Risk Behaviors/Sexual Concerns			
Low Energy/Fatigue				Alcohol/Drug Use			
Difficulty Concentrating				Eating Disorders (Binging/Purging/Restrictive)			
Difficulty Completing Tasks				Racing Thoughts			
Isolation from family, friends, etc.				Hyperactivity			
Feelings of Hopelessness				Impulsivity			
Somatic Symptoms (Headaches, Nausea, Body Aches)				Mood Swings			
Generalized Anxiety (Excessive Worry)				Anger Issues/Angry Outbursts			
Social Anxiety				Irritability/Low Frustration Tolerance			
Phobia				Aggressive/Disrespectful Behaviors			
Panic Attacks				Violent Behaviors			
Obsessive/Compulsive Behaviors				Academic/School Problems			
PTSD/Trauma Related symptoms (flashbacks, nightmares, etc.)				Work Problems (if employed)			
Grief/Loss				Home Problems (Disengaged, Disrespectful, etc.)			
Lack of Peer Support/Friends/Activities				Psychotic Symptoms (Delusional/Paranoia)			
Low Self-Worth				Dissociation/Detachment			
Poor Decision Making				Spiritual Concerns			

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Trauma/Loss History

Has client experienced past trauma and/or loss: □ Yes □ No

(Events triggering sense of safety/security) examples include physical/sexual/verbal abuse, exposure to domestic violence, drug abuse, neglect, or traumatic event such as: car accident, injury, death of loved one/significant person.

If yes, please list the event(s) that occurred, approximate age at the time of the event, and response to event (i.e., sought support/treatment, still unresolved/not addressed, etc.).

_____

_____

Family History

Is there a family history of mental health conditions?

Is there a family history of substance use/abuse?

Is there a family history of physical/sexual/verbal/emotional abuse?

If yes to any of above, please describe below:

_____

_____

_____

Family Concerns: Please check any family concerns/problems your family is experiencing.

	Communication Issues		Lack of Leisure/Fun Time
	Feeling Distant		Lack of Quality/Family Time
	Unresolved Conflicts		Medical Illness in Family
	Difficulty sharing feelings		Death in Family
	Strained Family Relations		Recently Moved
	Marital Separation/Divorce		Substance Abuse Issues
	Extended Family Disagreement		Mental Health Issues
	Remarried/Blended Family		Job Stress/Dissatisfaction
	Lack of Family Support		Job Loss
	Job Stress/Dissatisfaction		Other:

Family Status

If family has experienced separation/divorce, please describe current or past custody arrangement of your Adolescent (i.e., joint custody, partial custody, sole custody?

_____

Are there any co-parenting issues? □ Yes □ No If yes, please explain below:

_____

How would you describe the adjustment since separation/divorce and/or other family change?

_____

If Blended Family, are there concerns/problems that are impacting Adolescent? □ Yes □ No
If yes, please describe briefly below:

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Confidentiality Notice for Parents of Your Minor

Thank you for your commitment and investment to your child's mental health needs. LifeCare Counseling recognizes that as a parent, it may be challenging to not know all the intricate details of your child's therapeutic journey. However, for us to work collaboratively together, it is important that your son/daughter feel comfortable in sharing his or her thoughts and feelings and can process them fully within the context of a supportive therapeutic environment. This means that the therapeutic process in general, will be kept confidential between your Adolescent and the Therapist (i.e., session content, session processing, etc.).

It is also important to know that if there are any safety concerns or safety risks discovered during therapy with your Adolescent; you will be informed immediately to ensure his or her safety/well-being. For additional information regarding the limits to confidentiality, please refer to LifeCare Counseling Informed Consent & Clinical Agreement for Professional Therapy Services.

While therapeutic trust/rapport is critical to the outcome of any client's therapeutic journey; LifeCare Counseling fully aligns with and encourages parental/family involvement when working with minor clients. Periodic parental/guardian check-ins and/or family sessions help to promote good communication and the overall therapy goals you are seeking. Parents/Guardians may also be asked to come in (individually) if necessary to discuss general concerns/progress of client. Should you have any questions, please do not hesitate to ask.

Thank you for completing this intake form. Please sign & date below.

MINOR CLIENT SIGNATURE _____ Date: _____

PARENT/GUARDIAN SIGNATURE _____ Date: _____

PARENT/GUARDIAN SIGNATURE: _____ Date: _____