Center for Sexual Health
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CLIENT COMPREHENSIVE THERAPY INTAKE FORM FOR ADOLESCENT

Please fill out as completely as possible

Today's date: ________________________

Full name: **(First)** **(Middle)** **(Last)** **Preferred Name:**	**DOB:** **Age:**	**Assigned Sex at Birth:** **Current Gender Identity:**
Ethnicity (optional): **Caucasian** **AfricanAmerican** **Latino/Latina/Latinx** **Native American** **AsianAmerican** **Multi-racial** **Other (Describe):**		
How did you find out about the Center for Sexual Health?		

1. PRESENTING PROBLEM: Please define briefly the problems, challenges, and/or concerns for which you are seeking our services.

2. GOALS: Please list what you want to accomplish by participating in our program.

3. PERSONAL/PRIVATE INFORMATION: Are there any important things about yourself that you would like us to know (issues that might cause you shame, secrets, religious concerns, etc.)

4. RELATIONSHIPS: Who are the 3 most important people in your life right now? Do you turn to any of these people for help when you need it?

Are you in a romantic or sexual relationship? ____ Yes ____ Unsure ____No
Do you have any concerns about this?

5. RELIGION/SPIRITUALITY: Do you rely on religion or spirituality for guidance or support?

6. Below are a number of common mental health concerns for which adolescents seek help. Please indicate whether you think any have been a concern for you WITHIN THE LAST SIX (6) MONTHS, by checking "yes." Check "No" only if none of the words have been an issue for you.

Emotional Functioning			**Physical Functioning**			**Sexual Functioning**		
yes	no	Feel flat, empty, numb	yes	no	Eating problems	yes	no	Problematic sexual behavior
yes	no	Depressed, hopeless	yes	no	Fatigue, tiredness	yes	no	Too much focus on sexual things
yes	no	Suicidal thoughts and/or behavior	yes	no	Sleeping difficulties	yes	no	STD, HIV, AIDS concerns
yes	no	Sadness and/or crying	yes	no	weight loss	yes	no	History of sexual abuse
yes	no	Irritable/moody	yes	no	overweight	yes	no	Sexual orientation concerns
yes	no	Anger and/or rage	yes	no	Alcohol abuse	yes	no	Gender concerns
yes	no	Anxiety/worry	yes	no	Drug abuse	yes	no	Not liking genitals
yes	no	Fear and/or dread	yes	no	Pain and/or nausea			
yes	no	Nervous, shaky	yes	no	Serious illness and/or health problems			
yes	no	Self-harm thoughts/behaviors						
Self-Image and Coping Issues			**Mental Functioning**			**Relationship and Life**		
yes	no	Avoidance/Denial	yes	no	Memory problems	yes	no	Conflict, fighting
yes	no	Compulsivity	yes	no	Easily distracted	yes	no	Isolation, loneliness
yes	no	Shy or sensitive	yes	no	Buzzing in ears	yes	no	Being honest about self with others
yes	no	Low self-esteem	yes	no	Voices inside head	yes	no	Death and dying concerns
yes	no	Self-hatred, guilt, shame	yes	no	Troubling thoughts	yes	no	Grieving
yes	no	Feel ugly, poor body image	yes	no	Feel paranoid	yes	no	Work or school problems
			yes	no	Troubling dreams	yes	no	Family problems

Other current concerns (Please specify)

7. ALCOHOL/DRUG USE/ABUSE

Alcohol Use: Yes No
Average number of drinks per day: per week: per month:
Drugs: Yes No
Name of drug(s):

Average amount per day: ____ per week: __ per month: ____

Any history of alcohol or drug overuse/abuse/dependency? Yes No
Please describe:

Do you feel that your parent(s) have any problems with alcohol or drug use? Yes No
Please describe:

8. ABUSE HISTORY *None*

Type	Current	Past	Who abused you?	When/ Duration	Outcome (e.g. were they prosecuted?)
Sexual					
Physical					
Emotional/ Verbal					

Have you ever been witness to domestic violence?	**Yes No Describe:**
Have you ever been a victim of domestic violence?	**Yes No Describe:**
Have you ever been physically, emotionally, verbally, or sexually abusive to others?	**Yes No Describe:**

8. PARENTS OR GUARDIANS

How would you describe your relationship with your parents or guardians
Parent or Guardian 1:
Parent or Guardian 2:
If you have other caregivers, such as grandparents or stepparents who take care of you, please tell us information you think is important here:

9. SIBLINGS No Siblings

Name	*Age*	*How would you describe your relationship with this sibling?*

Name	Age	How would you describe your relationship with this sibling?

Which siblings are you close to?
___

10. EDUCATION

Grade	Name of School	Favorite Class/es	Academic Concerns?	Behavioral Concerns?

11. STRENGTHS: What do you consider your major strengths?

12. Any additional comments or issues you want to add?

Thank you for taking the time to complete this form. It will be helpful in your assessment and treatment.