

Metropolitan Marriage & Family Therapy, PLLC

Succeed at Your Relationship and Your Life!

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Intake: Confidential Adolescent Client Information

Date: _____

Name: _____ AKA: _____

Address: _____

Phone Numbers: Home: _____ Work: _____ Other: _____

E-Mail Address: _____ Date of Birth: _____ Age: _____

A. Ethnic Origin: _____ Place of Birth: _____
What is your religion? _____ Do you practice it? _____

B. School Name / Address:

What grade are you in?

Favorite Classes / Subjects:

How are you doing in school?

C. Name your special talents and skills:

D. Do you have a job? Yes _____ No _____

What kind?

Where?

E. Do you have a boyfriend / girlfriend? What's their name? How old are they?

Are you sexually active? Yes_____ No_____

Would you say you are primarily:

Heterosexual_____ (sexually attracted to the opposite sex)

Gay / Lesbian_____ (sexually attracted to the same sex)

Bisexual_____ (sexually attracted to either or both sexes)

Do you masturbate? Yes_____ No_____

How often? _____

F. Describe your social life?

G. Were you adopted? Yes_____ No_____

If you were not brought up by your biological parents, who raised you?

H. Do you have children of your own? Yes_____ No_____

Information on Children (if applicable):

Please fill in information below in the space indicated. Put "B" for biological children,

Name	Birthdate / Age	Gender (M / F)	Resides with
1)			
2)			
3)			

I. Who is currently living in your home? State name, gender, age and relationship.

J. How do you get along with them?

H. How is your health?

What serious medical illness have you had & when?

K. If you have had any of the following experiences, check each that applies to you:

- Periods of Depression, Feeling Down / Blue
- Suicide Attempts – tried to kill yourself
- Recurring Thoughts of Suicide – preoccupied with death and / or dying
- Use of Alcohol
- Use of Drugs / Mind Altering Substances
- Mental Illness
- Unexplainable Fatigue / Tiredness
- Problems Behavior, School Adjustment, or Performance
- Loss / Bereavement, Experience with Death
- Sexual Problems or Concerns
- Feelings of Loneliness, Moodiness, Sadness, Failure, Stress
- Coping with Chronic Illness
- Difficulty in Setting or Reaching Goals, Knowing What You Want
- Difficulties Talking with Significant Others
- Relationship Difficulties with Partner
- Physical Abuse
- Sexual Abuse
- Emotional / Verbal Abuse
- Erratic Sleeping Patterns
- Erratic Eating Patterns
- Anxiety, Fears/Phobias, Panic Attacks
- Difficulties Concentrating/Remembering Things
- Work Difficulties, Frequent Job Changes, Problems with Co-Workers
- Difficulties with Anger, Hostility, or Violence

L. Have you had problems with the law? Yes_____ No_____
Please explain and give dates?

Do you have any court cases right now? Please explain and give dates?

M. Have you received counseling before? Yes_____ No_____

What type, if any?

Individual Therapy_____ Family Therapy_____ Group Therapy_____

What was your past therapy experience like?

What would you like to resolve by coming to counseling now?

How can your therapist / counselor help you? What do you expect of them?

M. About Your Family:

1. Mother:

Describe your impression of your mother:

Describe your mother's behaviors – how she acts:

List feelings you have towards her:

How do you behave when around her / toward her:

2. Father:

Describe your impression of your father:

Describe your father's behaviors – how he acts:

List feelings you have towards him:

How do you behave when around him / toward him:

C. Experience Growing Up:

How does it feel to be in your family?

What are you like as a child in your family?

Describe your parents' relationship.

What wish(es) / dream(s) do you have as a child?

What are your strengths?

What are your weaknesses?

What are your hobbies?

XII. Additional Information:

Please share any other information that you feel will assist us in assessing your situation and getting to know you better.

Thank you for taking the time to thoroughly fill out this form. This information will assist us better service your needs.

Emma K. Viglucci, CFT, LMFT, CIT
Clinical Director