



Ingram & Associates Counseling & Consulting, Inc.
1402 Royal Palm Beach Blvd., Suite 400B, Royal Palm Beach, FL 33411
(561) 792-9242 Office || (561) 792-9243 Fax
www.ingramcounseling.com

ADOLESCENT INTAKE EVALUATION

Name: _____

Address: _____

City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Social Security #: _____

What grade are you in? _____ Gender: Male Female

How is your overall health? Very Good Good Average Poor

Who is your Doctor? _____

When was the last time you visited the Doctor's office? _____

Are you currently under a Doctor's care? Yes No

For what condition? _____

Do you use drugs? _____

What is your drug of choice? _____

How often? _____

Do you drink alcohol? _____

What is your drink of choice? _____

How often? _____

Do you use prescription drugs? _____

What kind? _____

How often? _____

Describe your relationship with your mother: _____

Describe your relationship with your father: _____

Where are you in the birth order? Oldest 2nd 3rd 4th Youngest Only

List your brothers and sisters in order of their age, including yourself:

Do you have a boyfriend or girlfriend? Boyfriend Girlfriend None

How old is he/she? _____ How did you meet? _____

Do your parents approve of this relationship? Yes No

If no, why not? _____

Types and length of employment: _____

Briefly describe what is troubling you: _____

Who have you discussed this with? _____

What was their response? _____

Check any of the following that you have experienced in the last six months:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Fear | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Guilt | <input type="checkbox"/> Peer Pressure |
| <input type="checkbox"/> Bitterness | <input type="checkbox"/> Health | <input type="checkbox"/> Problems with Mom or Step-Mom |
| <input type="checkbox"/> Change in lifestyle | <input type="checkbox"/> Homosexuality | <input type="checkbox"/> Problems with Dad or Step-Dad |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Recent Death | <input type="checkbox"/> Thoughts of Suicide |
| <input type="checkbox"/> Dishonesty | <input type="checkbox"/> Rebellion | <input type="checkbox"/> Unforgiveness |
| <input type="checkbox"/> Dislike of yourself | <input type="checkbox"/> Impotence | <input type="checkbox"/> Drugs/Alcohol |
| <input type="checkbox"/> Eating Difficulties | <input type="checkbox"/> Sexually Active | <input type="checkbox"/> Body Image Issues |
| <input type="checkbox"/> Envy (Jealousy) | <input type="checkbox"/> Suicidal Ideation | |

Signature: _____

Date: _____