Young Adult Intake Form

IDENTIFYING INFORMATION

Name: _____
Date of birth: _____ Age: _____ Grade/Level of education: _____
Race/Ethnicity: _____ Religious affiliation: _____
Today's date:_____
How did you hear of Dr. Jennie? _____

Home address: _____
City: _____ Province: _____ Postal Code:_____
Home phone: _____
Cell phone: _____

Best email to reach you?_____
Would you like to receive appointment confirmations by email? Yes ☐ No ☐
Can we contact you by email to let you know about groups or other updates about the clinic? Yes ☐ No ☐

Do you have Extended Health Care Insurance? Yes ☐ No ☐ Insurance Company Name:_____
Extended Health Care Insurance #:_____
Who will pay for sessions?_____

Emergency Contact Name: _____ Relationship: _____
City: _____ Phone Number: _____

MOTHER'S/GUARDIAN INFORMATION

Mother's/Guardian name: _____ Date of birth: _____ Home or cell phone: _____
Address: _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married: ☐ Common-Law: ☐ Single: ☐ Separated/Divorced: ☐ Widowed: ☐ or Other: ☐

Employment status (check all that apply)
Employed: ☐ Retired: ☐ Disabled: ☐ Student: ☐ Homemaker: ☐ Unemployed: ☐

If/When employed, what type of work does mother do? _____
Current employer is: _____
Years on current job: _____ Business Phone: _____

FATHER'S/GUARDIAN INFORMATION

Father's/Guardian name: _____ Date of birth: _____ Home or cell phone:_____
Address (if different from the mother's): _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married:☐ Live with partner:☐ Single:☐ Separated/Divorced:☐ Widowed:☐ or Other:☐

Employment status (Check all that apply)
Employed:☐ Retired:☐ Disabled:☐ Student:☐ Homemaker:☐ Unemployed:☐

If/When employed, what type of work does father do? _____
Current employer is: _____
Years on current job: _____ Business phone: _____

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____ Home or cell phone:_____
Address: _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married:☐ Live with partner:☐ Single:☐ Separated/Divorced:☐ Widowed:☐ or Other:☐

Employment status (Check all that apply)
Employed:☐ Retired:☐ Disabled:☐ Student:☐ Homemaker:☐ Unemployed:☐

If/When employed, what type of work does step-parent do? _____
Current employer is: _____
Years on current job: _____ Business phone: _____

STEP-PARENT'S INFORMATION

Step-parent's name: _____ Date of birth: _____ Home or cell phone:_____
Address: _____
Race/Ethnicity: _____ Religious affiliation: _____
Highest level of education: _____

Marital/relationship status (Check one)
Married:☐ Live with partner:☐ Single:☐ Separated/Divorced:☐ Widowed:☐ or Other:☐

Employment status (Check all that apply)
Employed:☐ Retired:☐ Disabled:☐ Student:☐ Homemaker:☐ Unemployed:☐

If/When employed, what type of work does step-parent do? _____
Current employer is: _____
Years on current job: _____ Business phone: _____

Dr. Jennie
CHILD & TEEN PSYCHOLOGIST

REASON FOR SEEKING TREATMENT

Please briefly describe the problems you are currently experiencing:

_____
_____
_____
_____

What has happened to cause you to seek help NOW?

_____
_____
_____
_____

What are your goals for therapy? What do you hope to achieve with treatment?

_____
_____
_____
_____

What do you consider to be other stresses in your life?

_____
_____
_____
_____

HISTORY OF THE PROBLEM

When did you first start experiencing the problem(s) that brought you to the office today?_____
_____

How often does the problem occur?_____
How long does it last? _____

Do you have any thoughts of harming yourself? Yes☐ No☐
Have you ever attempted to harm yourself? Yes☐ No☐ If yes, please explain:

_____
_____

Do you have any thoughts of harming someone else? Yes☐ No☐
Have you ever attempted to harm someone else? Yes☐ No☐ If yes, please explain:

_____
_____

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Have you had other previous therapy/counselling of any kind? Yes ☐ No ☐ If yes, when and for how long?

_____

What concerns were addressed in therapy?

_____

_____

Was this experience helpful (please explain)?

_____

_____

Have you ever been hospitalized for emotional/behavioural problems? Yes ☐ No ☐
If yes, when/where was this:

_____

_____

Have you ever experimented with alcohol/drugs? Yes ☐ No ☐
Do you currently do/take any of the following? (check)
☐ Smoke, if so, how many packs per ☐ day ☐ week
☐ Alcohol, if so, how much and how often?_____
☐ Recreational drugs, if so, how much and how often?_____
Other:_____

FAMILY HEALTH

Describe father's present health: _____

Describe mother's present health: _____

Have any family members been diagnosed with any of the following? (Please check if YES):

	If yes, please specify family member's relationship to you		
☐	**Cancer**	☐	**Mental Retardation**
☐	**Tourette's Syndrome**	☐	**Anxiety**
☐	**Diabetes**	☐	**Seizures/Epilepsy**
☐	**Heart Disease**	☐	**Reading Problems**
☐	**High Blood Pressure**	☐	**Speech/Language Problems**
☐	**Behaviour Disorder (i.e., ODD)**	☐	**Attention Deficit/Hyperactivity Disorder**
☐	**Depression**	☐	**Sleep Difficulties**
☐	**Autism Spectrum Disorder**	☐	**Alcohol/Drug Abuse**
☐	**Schizophrenia**	☐	**Kidney Disease**
☐	**Bipolar Disorder**	☐	**Migraine Headaches**
☐	**Multiple Sclerosis**	☐	**Physical Disability**
☐	**Alzheimer's Disease**	☐	**Stroke**
☐	**Other Learning Problem**	☐	**Tics**
☐	**Other significant health or emotional problem:**		

What kinds of stressful events have family members experienced recently?

_____
_____
_____
_____

What kinds of stressful events have you experienced recently?

_____
_____
_____
_____

How would you describe your relationship with your mother?

_____
_____
_____

How would you describe your relationship with your father?

_____
_____
_____

How would you describe your relationship with your step-parent?

_____
_____
_____

How would you describe your relationship with your sibling(s)?

_____
_____
_____

MEDICAL CARE AND HISTORY

Family Physician: _____ Clinic and Phone Number: _____
How often does you see a doctor? _____ Date of last visit: _____
Pediatrician: _____ Naturopathic Doctor: _____

Have you been prescribed medications? Yes ☐ No ☐
Please list all current medications you are currently taking: _____
_____
Supplements: _____
Have you had an eye exam? Yes ☐ No ☐ Date of last visit: _____
Have you had a hearing test? Yes ☐ No ☐ Date of last visit: _____

Do you have any history of the following (please check all that apply):

Condition	Age	Treated by whom?	Outcome of treatment
☐ **Serious accidents**			
☐ **Head injury**			
☐ **Serious illness**			
☐ **Surgery**			
☐ **Eye, ear, nose, or throat problems**			
☐ **Seizures**			
☐ **High fevers**			
☐ **Allergies**			
☐ **Loss of consciousness**			
☐ **Hospitalizations**			
☐ **Other:_____**			

EDUCATION

What is the highest level of education you have achieved so far? _____
What are your educational/career goals? _____

Describe any difficulties you are having regarding school or achieving your goals:
_____
_____
_____

WORK

Are you currently working? Yes☐ No☐ If Yes, how often?_____
Are you satisfied with your current employment situation?_____

FRIENDSHIPS & RELATIONSHIPS

Do you have close friends to talk to? Are you happy with the friendships you have?
_____
_____
_____

Are you sexually active? Yes☐ No☐ If yes, please continue.
Sexual preference:_____

Is there anything you feel is important that has not been addressed?

INTERESTS AND ACTIVITIES

Please describe your strengths and positive characteristics:

What extracurricular activities (i.e., sports, music, clubs, religious organizations) do you participate in?

What hobbies or interests do you have?

Any other information you feel is important and was not asked about?

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