



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 Psychology Group? \_\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Cell phone: \_\_\_\_\_

Best email to reach the you at? \_\_\_\_\_

Can we contact you by email to let you know about groups or other updates about the clinic?

Yes No

Would you like to receive appointment confirmations by email? Yes No

Emergency Contact Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

City: \_\_\_\_\_ Phone number: \_\_\_\_\_

MOTHER'S (GAURDIAN) INFORMATION

Mother's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Home or cell phone: \_\_\_\_\_ Address: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_

Highest level of education: \_\_\_\_\_

Marital/relationship status (Check one)

Married: Living with Partner: Single: Separated/Divorced: Widowed: Other:

If separated or divorced, do you have a court custody agreement? Yes No

(If yes, a copy of this document is required at the time this intake form is returned)

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 (GAURDIAN) INFORMATION**

Father's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Home or cell phone: \_\_\_\_\_ Address: \_\_\_\_\_  
 Race/Ethnicity: \_\_\_\_\_ Religious affiliation: \_\_\_\_\_  
 Highest level of education: \_\_\_\_\_

Marital/relationship status (Check one)  
 Married:      Living with Partner:      Single:      Separated/Divorced:      Widowed:      Other:

If separated or divorced, do you have a court custody agreement? Yes      No  
*(If yes, a copy of this document is required at the time this intake form is returned)*

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:      Living with Partner:      Single:      Separated/Divorced:      Widowed:      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: \_\_\_\_\_

Is it OK to contact stepparent at work? Yes No Is it OK to leave a message? Yes No

Special calling instructions? \_\_\_\_\_

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: Living with Partner: Single: Separated/Divorced: Widowed: 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: \_\_\_\_\_

Is it OK to contact stepparent at work? Yes No Is it OK to leave a message? Yes No

Special calling instructions? \_\_\_\_\_

## REASON FOR SEEKING TREATMENT

Please briefly describe the problems you are currently experiencing:

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What has happened to cause you to seek help NOW?

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

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

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## HISTORY OF THE PROBLEM

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

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How often does the problem occur? \_\_\_\_\_

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How long does it last? \_\_\_\_\_

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

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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 received previous counselling/therapy of any kind? Yes No  
If yes, when and for how long?

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What concerns were addressed in therapy?

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Was this experience helpful (please explain)?

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

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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 member’s 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
Behaviour Disorder (i.e., ODD)	Speech/Language Problems
Depression	Attention Deficit/Hyperactivity Disorder
Autism Spectrum Disorder	Sleep Difficulties
Schizophrenia	Alcohol/Drug Abuse
Bipolar Disorder	Kidney Disease
Multiple Sclerosis	Migraine Headaches
Alzheimer’s Disease	Physical Disability
Other Learning Problem	Stroke
High Blood Pressure	Tics
Other significant health or emotional problem:	

What kinds of stressful events have family members experienced recently?

Four horizontal lines for writing answers.

What kinds of stressful events have you experienced recently?

Four horizontal lines for writing answers.



How would you describe your relationship with your mother?

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How would you describe your relationship with your father?

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

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

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### MEDICAL CARE AND HISTORY

Family Physician: \_\_\_\_\_ Clinic and Phone Number: \_\_\_\_\_

How often do 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 taking:

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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			
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 & 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 your feel is important and was not asked about?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_