



## TriHealth EAP

### Adolescent Intake Form (Ages 12-17)

(If you feel uncomfortable or are unsure how to answer, leave that question blank and we will go over it together)

#### CLIENT INFORMATION

Name: \_\_\_\_\_

What name do you prefer to be called: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Additional Category (please specify): \_\_\_\_\_

Which pronoun do you prefer: he/ she/ they/ other (please specify) \_\_\_\_\_

Email Address: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

#### FAMILY INFORMATION

Are your parents single, separated, married or divorced? \_\_\_\_\_

If your parents are divorced, whom do you primarily live with? \_\_\_\_\_

How often do you see each parent? Mom \_\_\_\_\_ % Dad \_\_\_\_\_ %

How many brothers do you have? \_\_\_ Sisters? \_\_\_ Are you the oldest/ youngest/ middle?

#### FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

<input type="checkbox"/>	Fighting	<input type="checkbox"/>	Disagreeing about relatives
<input type="checkbox"/>	Feeling distant	<input type="checkbox"/>	Disagreeing about friends
<input type="checkbox"/>	Loss of fun	<input type="checkbox"/>	Alcohol or drug use
<input type="checkbox"/>	Lack of honesty	<input type="checkbox"/>	Trauma
<input type="checkbox"/>	Medical concerns	<input type="checkbox"/>	Getting along with siblings
<input type="checkbox"/>	Education problems	<input type="checkbox"/>	Divorce/ separation/ blended family
<input type="checkbox"/>	Financial problems	<input type="checkbox"/>	Birth of a child
<input type="checkbox"/>	Death of a family member	<input type="checkbox"/>	Job change or job dissatisfaction
<input type="checkbox"/>	Inadequate health insurance	<input type="checkbox"/>	Inadequate housing or space at home

	Too much social media use/ few rules		Too many rules around social media use
	Not enough access to technology at home		Other:

**FRIENDS/ ACITVITIES/ SCHOOL**

How do you consider yourself socially: \_\_\_ outgoing \_\_\_ shy \_\_\_ depends on the situation

Are you happy with the amount of friends you have? (Y/N) \_\_\_\_\_

Do you feel comfortable being with friends at school? (Y/N) \_\_\_ Outside of school? (Y/N) \_\_\_

Have you ever been bullied? (Y/N) \_\_\_\_\_

Are your parents happy with your friends? (Y/N) \_\_\_\_\_

Are you involved in any organized social activities (e.g. sports, scouts, music)?

\_\_\_\_\_

Do you like school? (Y/N) \_\_\_\_\_ What do you like about school? \_\_\_\_\_

Do you attend regularly? (Y/N) \_\_\_\_\_ How often are you tardy? \_\_\_\_\_

How do you do in school/ what are your typical grades? \_\_\_\_\_

What is your best subject? \_\_\_\_\_ Worst subject? \_\_\_\_\_

Do you feel you are doing the best you can at school? (Y/N) \_\_\_\_\_

**SUBSTANCE USE**

During the PAST 12 MONTHS, did you:

1. Drink any alcohol (more than a few sips)? (Y/N) \_\_\_\_\_  
(Do not count sips of alcohol taken during family or religious events.)

2. Use any nicotine (cigarettes, vaping, chewing tobacco)? (Y/N) \_\_\_\_\_

3. Smoke any marijuana or synthetic marijuana? (Y/N) \_\_\_\_\_

4. Use anything else to get high? (Y/N) \_\_\_\_\_

5. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs? (Y/N) \_\_\_\_\_

6. Do you feel pressured to smoke, drink to fit in? (Y/N) \_\_\_\_\_

**CURRENT REASON FOR SEEKING COUNSELING**

**Briefly describe the problem for which you are seeking counseling?**

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**What would you like to see happen as a result of counseling?**

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**Is there anything else you would like me to know?** \_\_\_\_\_

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**Client Signature**

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**Date**

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**Counselor Signature**

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**Date**