

# Hollywood Psychology Center

3595 Sheridan St., Suite 103, Hollywood, FL 33021

Tel: 954-981-8200 Fax: 954-237-4558

www.hollywoodpsychologycenter.com

## Confidential Youth Intake Information Questionnaire

Therapist's name \_\_\_\_\_ Lic # \_\_\_\_\_ Date \_\_\_\_\_

■ Child or Teenager's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_

Phone # - home \_\_\_\_\_ cell \_\_\_\_\_ work \_\_\_\_\_

E-mail \_\_\_\_\_

Birthplace \_\_\_\_\_ Parents Marital status \_\_\_\_\_

Parents/Guardians:

Name \_\_\_\_\_ Age \_\_\_\_\_ Currently living with child  No  Yes

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Currently living with child  No  Yes

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Siblings:

Name \_\_\_\_\_ Age \_\_\_\_\_ Currently living at home  No  Yes

Name \_\_\_\_\_ Age \_\_\_\_\_ Currently living at home  No  Yes

Name \_\_\_\_\_ Age \_\_\_\_\_ Currently living at home  No  Yes

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

Grades in school (how are you doing?) GPA \_\_\_\_\_

■ Religion/Ethnicity/Gender issues of note \_\_\_\_\_

■ Have you ever seen a school counselor or psychologist?  No  Yes If yes, when \_\_\_\_\_

What was the problem \_\_\_\_\_

Have you ever been seen by a probation officer?  No  Yes

If yes, why \_\_\_\_\_

List any major health problems: \_\_\_\_\_

List any medications you now take: \_\_\_\_\_

Have you been in counseling before?  No  Yes If yes, when \_\_\_\_\_

Counselor \_\_\_\_\_ Problem \_\_\_\_\_

Was counseling helpful \_\_\_\_\_

■ Who referred you \_\_\_\_\_

■ Please check any of the following that are currently troubling you:

- divorce
- jealousy
- stubbornness
- uncooperative
- headaches
- sleep trouble
- guilt
- appetite
- friends
- unhappiness
- school
- withdrawal
- making decisions
- self-control
- lying
- cheating (at school)
- feeling alienated
- family conflict
- weight loss
- weight gain
- low self-esteem
- health problems
- sex problem
- suicidal feelings
- restlessness
- short attention span
- aggressive feelings
- physical fighting
- can't be alone
- siblings
- disorganized
- losses, sadness: death
- sexual identity
- destructive behavior
- dating problems
- can't relax
- sexual abuse
- shyness
- confidence
- anorexia
- panic attacks
- drug use
- anger
- sleep too much
- nightmares
- fears
- energy level
- hate
- compulsions
- sadness
- loneliness
- temper
- depression
- alcohol use
- stress
- concentration
- defiance
- skipping school
- teachers
- teasing

■ At any time in your life, have you thought about hurting or killing yourself?  No  Yes

Did these thoughts include a plan and serious intent? If so, when and what were some of the details?

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■ What do you want to get out of this counseling? Please describe in a few words.

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■ Is there any more information that you think it's important for me to know?

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■ This form was completed by:

Parent/Guardian's signature

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■ **For clinical use only**

Diagnosis

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