CLARITY COUNSELING, INC.

YOUTH INTAKE FORM

Parent or Legal Guardian is asked to complete this form for any youth under the age of 18 in order to expedite the counseling process.

Date: ______________________ Youth's Name: ______________________

SSN: ______________________ DOB: ______________________

Religious Background: ______________________ Gender: ______________________

Youth's Family Member Information (include name, age, and type of relationship the family member has with the youth):

Father: ______________________

Mother: ______________________

Sibling(s): ______________________

Others: ______________________

Youth's Educational Background:

Current School: ______________________ Grade Level: ______________ Average Grades: __________

Any Behavior Concerns: __________ If yes, describe ______________________

____

How does the youth get along with peers? ______________________

Does the youth have an Individual Education Plan? ______________ If yes, what is it for? ______________________

____

Legal History: Has the youth ever been arrested? __________ If yes, indicate arrested for what and when: ______________

Developmental History: Does the youth have any developmental delays? __________ If yes, describe ______________________

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Trauma History: Has the youth experienced past trauma? __________ If yes, describe ______________________

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Medical History: Does the youth have any medical issues? __________ If yes, describe ______________________

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Date of last medical exam: ______________ Medical Doctor & Phone #: ______________________

Psychiatric History: Has the youth attended counseling previously? __________ If yes, describe ______________________

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Psychotropic Medications: Is the youth currently taking any psychotropic medications? ________________If yes, describe (current and past medications) ____

Alcohol/Drug Usage: Does the youth currently use alcohol or drugs? ______________If yes, describe (e.g., types, frequency) ____________

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Suicide Risk: Has the youth ever thought about or tried to hurt himself/herself? ________________________

If yes, when? ______________________________How many times?________________________

How or what did the youth plan to do?____

What were the circumstances at the time?____

Has anyone close to the child/youth ever committed suicide? ____________If yes, describe______________________

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Abuse History: Has the youth ever been physically, emotionally, or sexually abused?__________If yes, describe______________________

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Circle the following symptoms/behaviors that the child/youth has experienced in the last thirty days:

Sleep Disturbance	Weight Change	Lack of Motivation	Withdrawn
Change in Eating Behavior	Restlessness	Physical Complaints	Easily Annoyed or Irritated
Bedwetting	Uncontrolled Outbursts	Guilt/Remorse/Shame	Cruelty Towards Animals
Nightmares	Uncontrolled/Unprovoked Crying	Lack of Concentration	Feelings of Depression
Generalized Anxiety	Difficulty with Decisions	Specific Anxiety	Panic Attacks
Aggression	Nervousness	Fear	Self-Harming Behavior
Tension	Negativistic		

Others:____

Support Systems: Does the youth have people that he/she can turn to for support? ___________If yes, describe______________________

____

Strengths: What do you feel are the youth's strengths? ____

____

Presenting Issues: Briefly explain why the youth is seeking counseling at this time:________________________

____

Goals: What do you hope to achieve through counseling?____

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