

# Shelley Diefenbach, LPC

## Adolescent Counseling Intake Information

This form should be completed by the parent or guardian requesting counseling services for a minor child. The following information helps me learn a lot about your child very quickly and will become a part of your child's confidential record. Because I cannot guarantee the confidentiality of email communication, I do not recommend that you email the completed form back to me.

Date
Briefly describe the reason for this appointment.

Child's Background Information			
Full Name			
Preferred Name	Date of Birth	Gender	
Street			Apt/Unit
City	State	ZIP	
Phone	Email		
If child's parents are divorced, describe the custody arrangement. Include the year of the divorce.			
Describe your child's religious background (denomination, church, Sunday School, prayer life, concept of God, etc.).			
Describe what your child likes to do for fun, special interests, hobbies, etc.			
Referred By			OK to thank referral?    Y    N

Information about Child's Mother				
Name		Age	Race	
Street (if different)			Apt/Unit	
City		State	ZIP	
Cell Phone		OK to call?	Y	N
Home Phone		OK to call?	Y	N
Work Phone	Ext.	OK to call?	Y	N
Email		OK to email?	Y	N
Occupation	Employer		Hrs/wk	
Employer's Address				
Religious/Spiritual Affiliation		Church		
Briefly describe any physical/medical problems the child's mother currently has or is being treated for.				
Treating Physician		Medications		
List any previous psychological diagnosis (year diagnosed). May include ADHD, Bipolar Disorder, Major Depressive Disorder, etc.				
Previous Therapist/Counselor	Reason		Year(s)	

Information about Child's Father				
Name		Age	Race	
Street (if different)			Apt/Unit	
City		State	ZIP	
Cell Phone		OK to call?	Y	N
Home Phone		OK to call?	Y	N
Work Phone	Ext.	OK to call?	Y	N

Email		OK to email? Y N	
Occupation	Employer	Hrs/wk	
Employer's Address			
Religious/Spiritual Affiliation		Church	
Briefly describe any physical/medical problems the child's father currently has or is being treated for.			
Treating Physician		Medications	
List any previous psychological diagnosis (year diagnosed). May include ADHD, Bipolar Disorder, Major Depressive Disorder, etc.			
<b>Previous Therapist/Counselor</b>		<b>Reason</b>	<b>Year(s)</b>

<b>Family Members Living with Child</b>				
Enter the names of all the people who currently live in the child's home.				
Relationship	Name	Age	School Completed	Occupation

**Family Members Who Lived with the Child in the Past**

Enter the names of all the people who have previously lived in the child's home but don't any more.

Relationship	Name	Age	School Completed	Occupation

Using the scale below, please choose a number that reflects the extent of your concern about each of the issues listed below as it relates to your child. Please rate every item.

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0	1	2	3	4	5	6	7	8	9	10
No					Moderate					Extreme
Concern					Concern					Concern

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	Abuse		Fire Setting
	Adjustment to Parent's Remarriage		Loss/Grief
	Alcohol Use		Medical/Physical Issues
	Attention Deficit (ADHD)		Panic Attacks
	Anger		Relationship Difficulties
	Anxiety/Fear/Nervousness		School Performance
	Bedwetting/Soiling		Self-esteem
	Compulsive Behavior		Sexual Concerns
	Cruelty to Animals		Sleeping Concerns
	Cutting/Self-injury		Spiritual Concerns
	Depression/Sadness/Unhappiness		Social Anxiety
	Divorce/Separation of Parents		Stress
	Drug Use		Suicidal Thoughts/Talk
	Eating Concerns		Work
	Family Concerns		Other:

Academic/School Information		
School Name		
Grade	Teacher	Grades Repeated
Previous Schools Attended		Year(s)
How does your child get along at school?		
Describe any difficulties in learning at school.		
List any other family members who have had learning difficulties.		

Medical		
Describe any complications surrounding the child's birth.		
Sickness/Operation/Injury	Age	Severity
List any current medical problems.		

List any allergies.			
Any problems with child's vision?   Y      N		Any problems with child's hearing?   Y      N	
Last Physical Exam Date		Physician	
Physician Address			
<b>Prescription Drug/OTC/Supplement Name</b>	<b>Dosage</b>	<b># / Day</b>	<b>Prescribing Physician</b>

<b>Psychological</b>		
List any previous psychological diagnosis (year diagnosed). May include ADHD, Bipolar Disorder, Major Depressive Disorder, etc.		
Has your child had any previous psychological, psychiatric, neurological, or E.E.G. evaluations?   YES      NO		
If yes, list the name of the person who conducted the assessment, year, and reason for each assessment.		
Have your child ever been hospitalized for an emotional or mental health reason, including addiction?   YES      NO		
If yes, list the location, year and reason for each hospitalization.		
Has your child ever attempted suicide?   YES      NO		If yes, list the year(s) of attempt(s).
<b>Previous Therapist/Counselor</b>	<b>Reason</b>	<b>Year(s)</b>

**Other**

Is there anything else you would like me to know about your child?

I have read the Counseling Informed Consent and voluntarily request counseling services from Shelley Diefenbach, LPC for my minor child in accordance with the terms described on the Informed Consent document. My signature below attests to the accuracy of the above information and my agreement to these terms.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

The following two sections are to be completed by your child.

**Questionnaire**

- 1.) What is your favorite band or artist? \_\_\_\_\_
- 2.) What is your favorite TV show? \_\_\_\_\_
- 3.) How would you describe your school? \_\_\_\_\_
- 4.) What do you like the most about your parents? \_\_\_\_\_
- 5.) What frustrates you the most about your parents? \_\_\_\_\_
- 6.) What qualities do you appreciate the most about your best friend? \_\_\_\_\_
- 7.) What sports do you play or hobbies do you have? \_\_\_\_\_
- 8.) What is your favorite way to spend a Saturday? \_\_\_\_\_

**Sentence Completion**

- 1.) I would like \_\_\_\_\_
- 2.) If I were older \_\_\_\_\_
- 3.) Girls \_\_\_\_\_
- 4.) My friends think \_\_\_\_\_
- 5.) What makes me mad is \_\_\_\_\_
- 6.) My father \_\_\_\_\_
- 7.) I miss \_\_\_\_\_
- 8.) I am scared \_\_\_\_\_
- 9.) I often think of myself as \_\_\_\_\_
- 10.) My only trouble \_\_\_\_\_
- 11.) I dream of \_\_\_\_\_
- 12.) Being younger would \_\_\_\_\_
- 13.) I hate \_\_\_\_\_
- 14.) If I don't get what I want at home \_\_\_\_\_



- 15.) What worries me is \_\_\_\_\_
- 16.) When I grow up \_\_\_\_\_
- 17.) Nothing bothers me more than \_\_\_\_\_
- 18.) Other people think I'm \_\_\_\_\_
- 19.) I feel unhappy sometimes because \_\_\_\_\_
- 20.) Boys \_\_\_\_\_
- 21.) There are times when I \_\_\_\_\_
- 22.) Being my age is \_\_\_\_\_
- 23.) I don't think I can \_\_\_\_\_
- 24.) It's tough when \_\_\_\_\_
- 25.) At home \_\_\_\_\_
- 26.) Teachers are \_\_\_\_\_
- 27.) If only I were not so \_\_\_\_\_
- 28.) If I am left behind \_\_\_\_\_
- 29.) Sometimes I think about \_\_\_\_\_
- 30.) If I were smarter \_\_\_\_\_
- 31.) Sometimes I feel like \_\_\_\_\_
- 32.) It is more important to \_\_\_\_\_
- 33.) I wonder if I should \_\_\_\_\_
- 34.) My mother \_\_\_\_\_
- 35.) If my parents had only \_\_\_\_\_
- 36.) I would be happier if \_\_\_\_\_
- 37.) I'm glad I'm \_\_\_\_\_
- 38.) I wish I were \_\_\_\_\_
- 39.) If I could choose my family \_\_\_\_\_
- 40.) It would be funny if \_\_\_\_\_
- 41.) The world would be a better place if \_\_\_\_\_