



17101 Snowmobile Lane Suite 109
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Confidential Intake Form for Children and Adolescents

To Be Completed By Child/Adolescent Or If Necessary With Assistance

Child or Teenager's Name: _____ Today's Date: _____

Age: _____ Birth date: _____ Home Phone: _____

Address: _____
Street or P.O. Box City State Zip

E-mail address: _____ Parent I cell phone: _____

Parent II cell phone: _____

Birthplace: _____ Parent I Name: _____ age: _____
(or Guardian) Relation: _____

Parent II Name: _____ age: _____
(or Guardian) Relation: _____

Names and ages of siblings: _____
(please circle the names of those living at home)

Please list the adults and relation to you who live in the same house as you: _____

What do you do in your spare time: _____

School: _____ Grade: _____

How are you doing in school? _____ Grades earned? _____

Have you ever seen a school counselor or psychologist? Yes ___ No ___; If Yes, when? _____

Why? _____

Counselor's Name?: _____ Was Counseling Helpful? _____



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Have you ever been arrested? Yes ___ No ___; If Yes, why? _____

List any major health problems: _____

List any medications you now take: _____

Please circle any of the following which are currently troubling you:

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

Anything else-list here: _____

How do you hope counseling will help? _____

Is there anything else I should know about you? _____

Thank you for your patience in filling out his form. It will help me work more effectively with you. If you have any questions, please feel free to bring them up.

(Name of child, adolescent, parent or guardian completing form)