Karoll Counseling, LLC
744 Dulaney Valley Road, Suite 8B, Towson, MD 21204
Phone 443-535-3130 / Fax 410-630-3744

ADOLESCENT INTAKE QUESTIONNAIRE

This questionnaire will help me get to know a little more about your situation and how I may be of help to you. If you feel uncomfortable with any question you may leave it blank and we can discuss it when we meet.

Adolescent please fill out pages 1-6, if you think you may have an eating disorder please also complete pages 7-8. Parent/guardian. If have e please fill out page 9-16.

PATIENT IDENTIFICATION INFORMATION:

Name: _____ Date: _____

Gender: _____ Birth Date: _____ /_____ /_____ Age: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone (home): _____ May I leave a message? ▫ No ▫ Yes

Phone (cell): _____ May I leave a message? ▫ No ▫ Yes

E-mail: _____ May I email you? ▫ No ▫ Yes

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Race/Ethnic Origin: _____

Religious Preference: _____

PRESENTING PROBLEM(S):

Please describe the problem(s) or concerns for which you are seeking help at this time:

_____

_____

_____

_____

When did the problem(s) first appear or begin?

_____

_____

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What attempts have been made to deal with symptoms/problem before now?

_____

_____

What are you hoping to change/What would you like to see happen as a result of counseling?

_____

_____

COUNSELING/MEDICAL HISTORY:

Have you previously seen a therapist/counselor? ▫ Yes ▫ No

If yes, what did you find most helpful in therapy? _____

_____

What did you find least helpful in therapy? _____

_____

HARM TO SELF OR OTHERS:

Are you at current risk for harm from others or from self? ▫ No ▫ Yes if yes please explain:

_____

_____

Have you ever had suicidal thoughts or attempts? ▫ No ▫ Yes if yes, please explain:

_____

_____

Have you self-harmed /engaged in self-injurious behavior? ▫ No ▫ Yes

If yes, when was the first incident? _____When was the last incident? _____

What methods have you used and where on your body did you injure yourself?

_____

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TRAUMA/ABUSE HISTORY

Have you ever experienced an event you would describe as traumatic? ▫ No ▫ Yes

Have you ever felt threatened or bullied? ▫ No ▫ Yes

Witnessed/exposed to domestic violence? ▫ No ▫ Yes

Have you experienced any of the following: ▫ Physical Abuse ▫ Emotional Abuse ▫ Neglect ▫ Sexual Abuse ▫ Sexual Assault ▫ Unsure ▫ other _____ ▫ None

If yes was it reported to a Child Protective Services or similar agency? ▫ No ▫ Yes

comments:_____

Have you ever been the perpetrator of abuse? ▫ No ▫ Yes

CHEMICAL USE AND HISTORY:

During the PAST 12 MONTHS, did you: Drink any alcohol? (more than a few sips) ▫ No ▫ Yes
If yes, how often do you drink ____Daily ____Weekly ____ Occasionally ____Rarely
If yes, how much do you drink? _____ (#) per time.
During the PAST 12 MONTHS, did you: use tobacco? ▫ No ▫ Yes
If yes, how often do you smoke/vape/chew ____Daily ____Weekly ____ Occasionally ____Rarely
During the PAST 12 MONTHS, did you: smoke/ingest any marijuana? ▫ No ▫ Yes
If yes, how often do you smoke ____Daily ____Weekly ____ Occasionally ____Rarely
During the PAST 12 MONTHS, did you: Use anything else to get high? ("Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff.") ▫ No ▫ Yes
If yes, specify substance, amount, and frequency:
_____

LEGAL ISSUES:

Please list any legal issues that are affecting you or your family at present, or have had a significant effect upon your past: _____

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FAMILY HISTORY:

Are your parents married, separated or divorced? _____

Do you think their relationship is good (Y/N/Unsure) _____

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

How often do you see each parent? Mom _____% Dad _____%

FAMILY CONCERNS: (please check any family concerns that your family is currently experiencing)

	Fighting		Disagreeing about relatives
	Inadequate housing/feeling unsafe		Disagreeing about friends
	Feeling distant		Alcohol or drug use
	Loss of fun		Trauma
	Lack of honesty		Infidelity
	Medical concerns		Divorce/seperation
	Educational problems		Issues regarding remarriage
	Financial problems		Birth of child
	Death of a family member		Job change or dissatisfaction

Other concerns not listed: _____

_____

PEER RELATIONSHIPS:

How do you consider yourself socially; ____outgoing ____shy ____ depends on the situation

Are you happy with the amount of friends you have? ▫ No ▫ Yes

Explain: _____

Have you ever been bullied? ▫ No ▫ Yes

If yes, explain: _____

Are your parents happy with your friends? ▫ No ▫ Yes

Explain:_____

Are you involved in any organized social activities? (e.g. sport, music, theater) ▫ No ▫ Yes

If yes, explain: _____

SCHOOL HISTORY:

School: _____ Grade: _____

Do you like school? ▫ No ▫ Yes

If yes, what do you like about it? If no, what don't you like? _____

_____

Do you attend regularly? ▫ No ▫ Yes

If no, how often do you attend? _____

What are your current grades? _____

Do you feel you are doing the best you can at school? ▫ No ▫ Yes

If no, explain: _____

RELATIONSHIPS/SEXUAL ACTIVITY:

Are you in a relationship? If yes, for how long? _____

Have you ever been sexually active? ▫ No ▫ Yes Are you sexual activity? ▫ No ▫ Yes

Are you using brith control? If yes, specify: _____

LEISURE:

Hobbies/Interests? _____

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How do you cope with stress/relax? _____

_____

If you use social media (Facebook, Twitter, Snapchat etc.) what sites do you use, and often are you on them?

_____

PERSONAL STRENGTHS:

What are some of your strengths and/or accomplishments?

_____

_____

Is there anything else you would like me to know?

_____

_____

_____

_____

IF YOU DO NOT HAVE AN EATING DISORDER, YOU ARE NOW DONE WITH THIS QUESTIONNAIRE.

IF YOU DO HAVE AN EATING DISORDER, OR ARE UNSURE WHETHER YOU DO, PLEASE CONTINUE ONTO THE NEXT PAGE.

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EATING DISORDER HISTORY:

How old were you when you first struggled with difficult feelings, thoughts, and/or behaviors about food or weight? _____ years old.

What is the most and least you have weighed since age 13 and when was that?

Lowest weight since age 13: _____ Dates: _____

Highest weight since age 13: _____ Dates: _____

Have you struggled with these feelings, thoughts, and/or behaviors continuously since they began? ▫ No ▫ Yes

If you have had periods of no symptoms since the first onset of your ED, list the start & end dates of each period and what you think enabled you to give up the behaviors and what you think triggered your slip back to them. (If you are unsure of dates, estimate them.)

_____

_____

_____

24 HOUR RECALL:

In the last 24 hours, what did you eat and drink for:

Breakfast_____

Between breakfast and lunch _____

Lunch _____

Between lunch and dinner _____

Dinner_____

After dinner _____

Did you eat or drink anything other than the above (for example, glasses of water, alcoholic beverages, middle of the night)

_____

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FEMALES ONLY:

When was your last menstrual cycle? Month: _____ Year: _____

Are you on birth control/contraceptive medication? ▫ No ▫ Yes If yes, which one? _____

How old were you when you had your first period? _____ Years

CURRENT/MOST RECENT SYMPTOMS:

Check all the behaviors that best describe your CURRENT or MOST RECENT eating disorder symptoms

▫ Restrict food intake
▫ Binge eat
▫ Self-induce vomiting
▫ Feel compelled to exercise
▫ Abuse laxatives
▫ Check body/appearance very often
▫ Try to completely avoid certain foods
▫ Eat in the middle of the night
▫ Chew and then spit out the food
▫ Have food/eating rituals
▫ Diet
▫ Use drugs/alcohol to control appetite
▫ Feeling fat
▫ Think about weight/food a lot
▫ Abuse diuretics

Over the past 28 days, how frequently have you experienced/engaged in these behaviors?

_____

_____

Please describe any other problems you have with food and/or weight. _____

_____

_____

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ADOLESCENT INTAKE QUESTIONNAIRE

Adolescent's Name: _____ DOB: _____

Mother/Guardian's Name: _____ Best way to contact: _____

Mother/Guardian's Address: _____

_____

Father/Guardian's Name: _____Best way to contact: _____

Father/Guardian's Address: (if different than above): _____

_____

EMERGENCY CONTACT:

Name _____

Relationship to child _____ Phone _____

PRESENTING PROBLEM(S):

Please describe the problem(s) or concerns for which your adolescent is seeking help for at this time:

_____

_____

_____

When did the problem(s) first appear or begin?

_____

_____

Whom else have you consulted about your child's problem(s)?

_____

_____

What attempts have been made to deal with symptoms/problem on your own?

_____

_____

What are you hoping to change/What would you like to see happen as result of therapy?

_____

_____

What is most concerning right now? _____

In the last year, have you experienced any significant life changes or stressors? If yes, please explain:

_____

_____

PRIOR TREATMENT:

Has your son/daughter previously seen a therapist?
If yes, please identify name of provider, approximate dates of treatment and reason he/she received treatment.

_____

_____

_____

Has your son/daughter previously seen a psychiatrist or psychiatric nurse practitioner?
If yes, please identify name of provider, approximate dates of treatment and reason he/she received treatment.

_____

_____

Does you son/daughter take any medication for mental heath concerns? Yes ___ No__
If yes, specify name of medication, prescriber, reason it was prescribe and dosage:

_____

_____

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Has you child has any hospitalizations or treatment stays (inpatient, residential, PHP, IOP) for psychiatric reasons, (including substance use) please identify reason, name/location and duration of stay:

_____

_____

What was helpful/unhelpful about previous treatment? _____

_____

Does your child have a pervious mental health diagnosis? If yes, specify:

_____

PRIOR TESTING:

Has your child received prior psychological testing? Yes _____ No_____ Please bring or list results.

FAMILY PSYCHIATRIC HISTORY:

Has the child's **FATHER or FATHER'S** relatives had similar or other psychiatric problems?

Yes_____ No _____ If yes, please describe including treatment:_____

_____

_____

Has the child's **MOTHER or MOTHER'S** relatives had similar or other psychiatric problems?

Yes_____ No _____ If yes, please describe including treatment:_____

_____

_____

Does the child's **BROTHER(S) or SISTER(S)** have any psychiatric problems?

Yes_____ No _____ If yes, please describe including treatment:_____

_____

_____

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FAMLY HISTORY:
(Please answer the following the best you can, I understand that you may not be able to answer of the questions pertaining to the other parent.)

Farther's name: _____ **DOB:** _____ **Age:** _____

Phone: _____ Email: _____

Education: _____ Occupation: _____

Employment: _____ Military experience? Y/N _____

Assessment of current relationship if applicable: Poor____ Fair ____ Good ____ Other: _____

Mother's name: _____ **DOB:** _____ **Age:** _____

Phone: _____ Email: _____

Education: _____ Occupation: _____

Employment: _____ Military experience? Y/N _____

Assessment of current relationship if applicable: Poor____ Fair ____ Good ____ Other: _____

PARENTS MARITAL STATUS:

▫ Single ▫ Married (legally) ▫ Divorced ▫ Cohabiting ▫ Divorce in process ▫ Separated
▫ Widowed ▫ Other _____

Length of marriage/relationship:_____

If divorced, how old was your child at time of divorce? _____

How long married ?_____ If divorced, date of divorce: _____

Any previous marriages? Describe:_____

If divorced, how much time does you child spend with each parent?

Mom _____% Dad _____%

Is your child adopted? Yes _____ No_____

If yes, please describe the circumstances of the adoption: _____

_____

Other relatives or persons living in the home, including siblings (indicated age and relationship):

_____

Siblings/half-siblings NOT living in the home: _____

_____

SCHOOL INFORMATION:

Name of school: _____ Phone #: _____

Teacher's name: _____ Grade: _____

Type of school: Public: _____ Private: _____ Special: _____

Any problems in school regarding academic performance? If yes, explain:

_____

Any changes in grades or attitude towards school? If yes, explain:

_____

Any known learning disabilities? If yes, explain:

_____

Is your child in any special programs (speech, reading, etc.) Give names of tutors if relevant. If yes, explain:

_____

GENERAL HEALTH INFORMATION:

How would you rate your child's current physical health?
Poor ▫ Unsatisfactory ▫ Satisfactory ▫ Good ▫ Very good

Please list any persistent physical symptoms or health concerns he/she may have:

_____

Does she/he have a pediatrician? If yes, who is it_____

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When was his/her last physical _____

Please list any current medication to manage his/her physical health concern(s):

_____

Any conflicts or problems around child's early childhood or current eating behaviors? specify:

_____

_____

Is there any family history of medical illnesses (e.g., seizures, thyroid problems, allergies)?
f yes, please describe:

_____

Does your son/daughter have other previous medical hospitalizations?

If yes, please describe: _____

SUBSTANCE USE:

Do you have any concerns with you son or daughter using alcohol or drugs? ▫ No ▫ Yes

If yes, please explain your concerns:

_____

_____

If there is addictions in your family please describe: _____

_____

INTERNET/ELECTRONIC COMMUNICATION USAGE:

Do you have any concerns with your son or daughter using the internet or electronic communication such as Facebook, Snapchat, Twitter, texting etc.. ▫ No ▫ Yes

If yes, please explain your concerns:

_____

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LEGAL ISSUES:

Please list any legal issues that are affecting you or your family, son or daughter, at present or have had a significant effect upon you or your child in the past:

_____

ADDITIONAL INFORMATION:

What do you consider some of your son or daughter's strengths?

_____

_____

What do you consider to be some of his/her weaknesses/struggles?

_____

_____

Any additional information that you would like me to know:

_____

_____