Hollywood Psychology Center

3475 Sheridan Street, Suite 309, Hollywood, FL 33021 | 954-981-8200 *tel* 954-381-5979 *fax*

Confidential Youth Intake Information Questionnaire

(Child to Fill Out)

Name Age Birthdate

Address

Phone # - home cell work

E-mail

Birthplace Parents Marital status

Parents/Guardians:

Name Age Currently living with you ☐ No ☐ Yes

Name Age Currently living with you ☐ No ☐ Yes

Siblings:

Name Age Currently living with you ☐ No ☐ Yes

Name Age Currently living at with you ☐ No ☐ Yes

Name Age Currently living at with you ☐ No ☐ Yes

School Grade

Grades in school (how are you doing?) GPA

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

Problem

Was counseling helpful

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

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

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

Did you think about how or when you would do it? If so, when and what were some of the details?

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

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

This form was completed by:

Parent/Guardian's signature

For clinical use only

Diagnosis