Lakewood Counseling and Career Center

6607 18th Avenue South ● Suite 101 ● Richfield, MN 55423 ● 612-798-7373 ● Fax 612-243-3615

Adolescent Intake Information

Basic Information

Name ____________________________ **Date of Birth** ______________ **Gender** ____

My current address ____
Street/House # City State Zip Whose house is this?

I was born and raised at ____
Where With who

People living with me now are: **Name** **Relationship** **Age**

____
____
____
____

More In Depth Information About Me and My World

Place a check on each line below that you consider to be true. Consider each in terms of how you've felt at any time in the last six months.

__ I have a strong supportive group of friends.
__ I have experimented with drugs/alcohol
__ My friends are a good influence for me.
__ There is a lot of gang activity around me.
__ I feel supported by my family.
__ My family wants me to be independent
__ I feel comfortable in my school.
__ At times my life feels hopeless
__ I feel I'm successful at school
__ I'm comfortable with my looks.
__ My culture or gender is an issue for me.
__ My eating habits are good.
__ I feel that I need counseling.
__ My physical health is not good.
__ I worry about someone in my family.
__ Sometimes I cry for no real reason.
__ I get angry and I don't know why.
__ I am sexually active.
__ I feel my friends worry about me.

___ I have a hard time concentrating.
___ I'm comfortable with my weight.
___ I like taking responsibility around the house.
___ My parents set fair limits for me.
___ I have trouble sleeping.
___ I get all of my homework done on time.
___ I am involved in extra activities at school.
___ I am absent from school often.
___ There is too much conflict in my house.
___ I have seen guns in school or the neighborhood.
___ I am scared at home or in school.
___ I have been arrested before.
___ My moods can go up and down quickly.
___ I am sexually active.

Turn over

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Medical Information

My doctor's name is ______________________________His/her phone number is___________
Medical problems I have are ____
____
(For example: high blood pressure, diabetes, asthma, etc.)
Times that I have been in the hospital ____
(List reason and approximate age) ____
____
Current medications that I take ____
____

More About Me

The three things that I consider my greatest strengths are:
1. ____
2. ____
3. ____

My friends would say that my three greatest strengths are:
1. ____
2. ____
3. ____

Three parts of myself or my life that I need to work on are:
1. ____
2. ____
3. ____

My hobbies or interests are:
1. ____
2. ____
3. ____

Thanks for your honesty!

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