William J. Mace, Ph.D
Adolescent Intake Form

Patient Initials: ___________

The information you provide is for professional use only. Please answer all questions to the best of your ability.

Patient's Full Name _______________________________ **Date**____________

Birth Date__________ Age ______ Sex________

Address__________________________ City______________ State_____ Zip _________

Phone: Home______________ Cellular______________Email _____________________

General Physician_________________________ Referred By__________________________

As a means to do our best to help you, please explain your expectations regarding Focus. What do you hope to accomplish? What do you expect to gain from your visits? ____________________________

____

FAMILY

Father's Name _______________________________________ Birth Date ____________

Address (if different) ___________________________________ Phone ________________

Education/Degree ____________________________ Occupation ____________________

Mother's Name _______________________________________ Birth Date ____________

Address (if different) __________________________________ Phone ________________

Education/Degree ___________________________ Occupation _____________________

Parents' marital status: Single Married Separated Divorced Never married

Parents divorced? ______________ If yes, your age at the time ? __________

If deceased, when? _____________ If yes, your age at the time? __________

If not your parents, who is your legal guardian/primary caregiver? (if applicable)

Name(s) (if not provided above) ____

Relationship to patient (if applicable) ____

Address (if different) ___________________________________ Phone ________________

Education/Degree ___________________________ Occupation _____________________

Guardian's marital status: Single Married Separated Divorced Never Married

	Name	Age	Any related difficulties?
Siblings:			

Others currently living in your home: ____

What important things have happened to you or your family in the last six months?

____

____

Have there been any recent changes or difficulties in the home that you think are important for me to know?

____

____

Tell anything else about your family in the space below that you think would be helpful for me to know.

____

BIO-MEDICAL and DEVELOPMENTAL HISTORY

Did your mother experience problems during her pregnancy with you?

____

Were there any complications during your birth?

____

Birth weight: ______ Length of gestation (weeks): ______ Normal birth? ______

As a child, did you meet all developmental milestones around the correct age? ______ If not, please explain: ____

List any physical or medical conditions that affect your functioning: ______________________________

____

What aches, pain, or physical discomforts have you experienced recently? __________________________

____

Do you have any significant medical conditions? If yes, please describe .___________________________

____

When was the date of your last medical check-up? ____

Have you had a recent blood workup? _______ Any significant findings? __________________________

____

Do you exercise regularly? __________ If yes, how often? ______________________________________

Have you ever experienced a significant accident (i.e. wreck, concussion, serious injury)? ________________

____

Surgical Operations? ____

When was your last *formal* eye exam? ______ Results: ______

When was your last *formal* hearing exam? ______ Results: ______

Family history of mental illness/substance abuse/learning disabilities? ___________________________

____

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Please list all medications that you are currently taking including natural supplements:

Name	Frequency	Dosage	Reason

Do you or did you use any of the following?

☐ Alcohol

How much ________________ How often________________ Age at first use: _____

☐ Recreational drugs: ______ Type(s): ____

How much _____________________ How often___________________ Age at first use: _____

☐ Tobacco Products? Type(s): _________________________

How much _____________________ How often ___________________ Age at first use: _____

Circle the caffeine products you consume regularly:

Coffee Tea Soft Drink Energy Drink Chocolate Medications w/caffeine

Total average of cups/mgs daily _________________At what times throughout the day? ________________

Please check all that apply for current or past:

	Current	Past		Current	Past
Headaches			Dizziness		
Stomach Problems			Sleep Issues		
Memory Problems			Confusion		
Paranoia			Impulsive Behavior		
Depression			Mood Swings		
Euphoria			Binging		
Excessive Energy			Unusual Thoughts		
Weird Feelings			Weight Loss		
Weight Gain			Poor Concentration		
Worthlessness			Hopelessness		
Helplessness			Low Energy		
Crying a lot			Irritable Mood		
Legal Problems			Financial Problems		
Suicidal Thoughts			Homicidal Thoughts		
Worried a lot			Phobias		
Fears			Panic Attacks		
Grades Dropping			Anger Problems		

PRESENTING PROBLEM

In your own words, what are the problems or difficulties you are experiencing? ________________________

____

____

____

____

What has been tried on your own to help with the difficulties? ______________________________________

____

____

When did these difficulties first begin? ____

Does the difficulty occur at home? _____________ Work? _____________ Other? ______________________

____

Have you tried to get any previous help for this? __________ What kind? ____________________________

____

Where?_____________________________ Was this helpful? __________ How? _____________________

____

Have you ever had a psychological/educational evaluation? _______ If so, what tests were given? __________

____

Results/Recommendations? ____

Who performed the assessment? _____________________________________ When? _______________

Other assessments:

Occupational Therapist ______ If so, what tests were given: ______________________________________

Who performed the assessment? _____________________________________ When? _______________

Results/Treatment? ____

Language/Speech Pathologist _______ If so, what tests were given: _________________________________

Who performed the assessment: _____________________________________ When? _______________

Results/Treatment? ____

Have you ever had therapy or counseling? _________ When? ____________ _____How long? _____________

If yes, counselor's name : ____

What changes have you noticed recently in your behavior and/or mood (if applicable)? ___________________

____

____

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Who is a part of your emotional support system?

Family: ____

Friends: ____

Other: ____

What do you consider your strengths? ____

____

What hobbies/activities do you enjoy? ____

____

Do you ever have trouble relating to your peers? ________ Or, feel unsure in social situations? ____________

If yes, explain: ____

____

____

____

SCHOOL HISTORY

Please provide all schools/preschools/day cares you have attended:

____

____

Briefly list the highest level of formal education you have obtained and any other relevant education, certifications, or specialized training:

____

Your grades: ☐ Above average ☐ Average ☐ Below Average

In what subjects do/did you earn your highest grades? ____

____

In what subjects do/did you earn your lowest grades? ____

____

Did you ever repeat/skip a grade? (explain) ____

____

What are/were your favorite subjects? ____

____

Do/did you experience problems with homework? _______ How? ____

____

Do/did you experience problems with tests? _______ How? ____

____

What other special school problems did you experience? ____

____

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WORK HISTORY

Are you employed? YES _____ NO _____

Current job title/employer: ____

Briefly list past work experience: ____

____

Years in current position ________ Are you having any difficulties/stressors in your current job?

If so, please briefly describe those difficulties: ____

____

____