St Louis DBT

Welcome to St Louis DBT. The information requested here is important for your care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (ages 12-17)

Adolescent please fill out pages 1-4. Parent/guardian please fill out pages 5-9

CLIENT INFORMATION

Name: _____ Date of Birth _____

Male __ Female ___ Other _____ Preferred pronouns _____ Age _____

Cell phone: _____Messages ok?___ Text reminder ok?_____

School: _____ District _____ Grade: _____

SOCIAL MEDIA & CELL PHONE

What social media do you use (FaceBook, Twitter, SnapChat, Instagram, etc)? _____
_____

Do your parents have access to your social media and/or cell phone? (Y/N) _____Do they have any issues with your use of phone, text, social media or other electronic communication? (Y/N) _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try? _____
_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe) _____
_____

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for? _____
_____

What would you like to see happen as a result of counseling? _____
_____

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? ___ Yes ___ No
If yes, what did you find **most helpful** in therapy? _____
_____

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

SUBSTANCE USE AND HISTORY

Do you currently use alcohol? _____Yes, _____No
If yes, how often do you drink? _____Daily, _____Weekly, _____Occasionally, _____Rarely
If yes, how much do you drink? _____(#) per time.

Do you currently use Tobacco? _____Yes, _____No If yes, how much do you smoke/chew? _____

Do you currently use any other drugs? _____Yes, _____No
If yes, what drugs do you use? _____
If yes, how often do you use? _____Daily, _____Weekly, _____Occasionally, _____Rarely
Have you received any previous treatment for alcohol or substance use? ____Inpatient _____Outpatient
If so, where?_____

Please answer the following with Y/N.

1. Have you ever used more than one substance/alcohol at the same time to get high? _____
2. Do you avoid family activities so you can use? _____
3. Do you have a group of friends who also use? _____
4. Do you use to improve your emotions such as when you feel anxious, sad or depressed? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present, or have had a significant effect on you in the past. _____

FAMILY HISTORY

1. Are your parents never married, married or divorced? _____
2. How would you describe their relationship? _____
3. Who do you primarily live with? _____ mom ___ dad ____ relative _____ other _____
4. How often do you see each parent? Mom_____% Dad _____%.
5. Did you experience any abuse as a child in your home or outside your home (physical, verbal, emotional, or sexual)? Please describe as much as you feel comfortable. _____
_____

Do you argue with your parents? (Y/N) _____
If so, how often? ___ daily ___ 4-7 times/week ___ 1-3 times/week ___ Less than once a week
If so, do you __ yell ___ throw/break things ___ leave ___ punch walls ___ physically hurt others ___ withdraw
If so, do your parents __ yell __ throw/break things __ leave __ punch walls __ physically hurt you ___ withdraw

Check all of the issues you argue most about:

- ☐ Chores
- ☐ Friends, boyfriends, girlfriends
- ☐ Substance or alcohol use
- ☐ Curfew, rules, punishments
- ☐ Sexual activity, gender identity, sexual orientation
- ☐ Social media, internet, cell phone use
- ☐ Homework, grades, school attendance
- ☐ Sleeping, eating, hygiene
- ☐ Different ideas about what choices are reasonable or acceptable
- ☐ Feeling blamed, judged, abandoned, invisible, misunderstood, unheard
- ☐ Yelling, property damage, violence
- ☐ Getting in trouble at school
- ☐ Illegal activities, legal problems
- ☐ Other _____

FAMILY CONCERNS

(Please check any concerns that your family is currently experiencing)

- ☐ Lack of communication
- ☐ Mental health problems
- ☐ Physical health problems
- ☐ Dirty, insect or rodent infested housing
- ☐ Housing in poor repair
- ☐ Unsafe neighborhood
- ☐ Secrets, dishonesty
- ☐ Drug or alcohol abuse
- ☐ Problems with relatives
- ☐ Fighting among family members
- ☐ Physical fights
- ☐ Infidelity
- ☐ Financial problems
- ☐ Issues regarding remarriage
- ☐ Death of a family member(s)
- ☐ Birth of a child or sibling
- ☐ Abuse or neglect
- ☐ Inadequate health insurance
- ☐ Job loss, change or job dissatisfaction
- ☐ Other concerns not listed above _____

PEER RELATIONS

1. How do you consider yourself socially: ___outgoing ____shy ____depends on the situation.
2. Are you happy with the number of friends you have? (Y/N)_____
3. Do you have a friend(s) you trust to confide in? (Y/N) _____
4. Have you ever been bullied? (Y/N) _____ If so, starting in grade _____ until grade _____
5. Are your parents happy with your friends? (Y/N)_____
6. Are involved in any organized social activities (e.g. sports, scouts, music, debate)? _____

SCHOOL HISTORY

1. Do you like school? (Y/N)_____
2. Do you attend regularly? (Y/N)_____
3. What are your current grades? _____
4. Have your grades changed since last year (Y/N) _____ If so, are they _____ improving _____ declining?
5. Do you feel you are doing the best you can at school? (Y/N) _____

INDIVIDUAL CONCERNS

(Check none, mild, moderate or severe for each concern

Symptom	None	Mild	Moderate	Severe
SADNESS				
APPETITE CHANGES				
CRYING				
SOCIAL ISOLATION				
SLEEP DISTRUBANCES				
PARANOID THOUGHTS				
PROBLEMS AT HOME				
POOR CONCENTRATION				
HYPERACTIVITY				
INDECISIVENESS				
BINGING/PURGING				
LOW ENERGY				
LONELINESS				
EXCESSIVE WORRY				
UNRESOLVED GUILT				
LOW SELF WORTH				
IRRITABILITY				
ANGER ISSUES				
NAUSEA/INDIGESTION				
SPIRITUAL CONCERNS				
SOCIAL ANXIETY				
SEEING/HEARING THINGS NOT THERE				
SELF MUTALATION				
UNPLANNED WEIGHT GAIN/LOSS				

Symptom	None	Mild	Moderate	Severe
RACING THOUGHTS				
CUTTING				
RESTLESSNESS				
IMPULSIVITY				
DRUG USE				
MARIJUANA USE				
NIGHTMARES				
ALCOHOL USE				
HOPELESSNESS				
EASILY DISTRACTED				
ELEVATED MOOD				
TRAUMA				
FLASHBACKS				
MOOD SWINGS				
OBSESSIVE THOUGHTS				
DISORGANIZED				
PANIC ATTACKS				
ANOREXIA				
FEELING ANXIOUS				
GRIEF				
FEELING PANICKY				
PHOBIAS				
SUICIDAL THOUGHTS				
HEADACHES				
PAST SUICIDE ATTEMPTS				
OTHER (please specify)				

*We would like you to know that we have worked with a lot of adolescents and we respect your privacy. We hope to create an atmosphere where you feel comfortable sharing

St Louis DBT

Welcome to St Louis DBT. Please note that the information is important for your child's care. Please fill out forms as completely as possible and have them ready before your first counseling session.

ADOLESCENT INTAKE FORM (PARENT SECTION)

Your Name _____ Relationship _____ Age _____

Email _____ Cell phone _____

Adolescent's Name: _____ Date of Birth _____

Physical Address _____ City _____ State __ Zip _____

Race/Ethnic Origin: _____ Religious Preference: _____

HOUSEHOLD: People Living With Adolescent (Attach sheet if additional space needed)

First & Last Name	**Relationship**	**Age**	**Gender**	**Type** (e.g., bio, step, etc)

Current Reason For Seeking Counseling For Your Adolescent

Briefly describe the problem for which your adolescent is seeking to have counseling? _____

_____

_____

What would you like to see happen as a result of counseling? _____

_____

_____

What about your adolescent is most concerning right now? _____

_____

_____

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child? Yes ___ No ___ If yes, describe:

_____

2. Did your child have health problems at birth? Yes _____ No _____

If yes, describe: _____

3. Did your child experience any developmental delays (e.g. toileting, walking, talking)? Yes __ No ___ Unsure__

If yes, describe: _____

4. Did your child have any unusual behaviors or problems prior to age 3? Yes ___ No ___

Unsure___ If yes, describe: _____

5. Has your child experienced emotional, physical, or sexual abuse?
Yes ____ No ____ Unsure _____ If yes, describe: _____

MENTAL HEALTH HISTORY

Has your son or daughter previously seen a counselor? ___ Yes ___ No (add additional sheets, if needed)
If yes, when? _____ With whom? _____
For what reason did your son or daughter go to counseling? _____
Does your son or daughter have a previous mental health diagnosis? _____
What did you find **most helpful** in therapy? _____
_____
_____
What did you find **least helpful** in therapy? _____
_____
_____
Has your son or daughter used psychiatric services? Yes____ No____
If yes, who did he or she see? _____
If yes, was it helpful? N/A____ Yes____ No_____
Has your son or daughter taken medication for a mental health concern? Yes_____ No _____

Names of medications	Approximate dates taken	Was it helpful? Y/N

Has your son or daughter been hospitalized for mental health issues? Y/N _____ (attach add'l sheet if needed)
If yes, when? _____ Where? _____
Has he or she been in an Intensive Outpatient Program (IOP)? Y/N _____(attach additional sheet, if needed)
If yes, when? _____ Where? _____
Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____
If so, please describe. _____
_____
_

SUSTANCE USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____
If yes, please explain your concern: _____
_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter use of the internet, social media, text or other electronic communication (e.g., Facebook, Snapchat, Twitter, Instagram, texting, etc? (Y/N) _____
If yes, please explain your concern: _____
_____

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 on you or your son or daughter in the past.

_____
_____
_____

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3? Y/N _____

If yes, describe _____

BIOLOGICAL OR ADOPTIVE PARENTS' RELATIONSHIP STATUS

__ Single __ Married__ Divorced __ Cohabitating __ Divorce in process__ Separated __ Widowed ___Other

Length of relationship? _____ Length of marriage? _____

If relationship ended, how old was your child at time of divorce or end of relationship? _____

If relationship ended, how much time does your child spend with each parent? Mother_____%, Father _____%

Please answer the following as best as you can.

Biological or Adoptive Parent's Name _____Birth Date _____

Ethnic Origin: _____ Gender _____ Age _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N ___ Combat experience? Y/N ___ History of mental illness? Y/N ___ What? _____

Current Status ____Single ___ Married ___ Divorced ___ Separated ____ Widowed ____ Remarried ____ Other

If remarried, step's name _____ Birth Date _____ Age _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Biological or Adoptive Parent's Name _____Birth Date _____

Ethnic Origin: _____ Gender _____ Age _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N ___ Combat experience? Y/N ___ History of mental illness? Y/N ___ What? _____

Current Status ____Single ___ Married ___ Divorced ___ Separated ____ Widowed ____ Remarried ____ Other

If remarried, step's name _____ Birth Date _____ Age _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

Complete only if adolescent lives with someone other than a biological or adoptive parent

Name _____Birth Date _____

Do you have legal guardianship? Y/N _____ Relationship? ___ Grandparent ___ Other Relative ___ Other

If other, describe _____Years Living with You? _____

Ethnic Origin: _____ Gender _____ Age _____

Total years of education completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Are you living with a partner or spouse? Y/N _____ If yes, name _____

Assessment of current relationship if applicable: Poor_____ Fair_____ Good_____

YOUR STRENGTHS AS A PARENT

What positive parenting skills would you say you have? _____

_____

_____

What parenting skills do you need/want to strengthen? _____

_____

_____

FAMILY CONCERNS

Please check any concerns that your family is currently experiencing

- ☐ Lack of communication
- ☐ Mental health problems
- ☐ Physical health problems
- ☐ Dirty, insect or rodent infested housing
- ☐ Housing in poor repair
- ☐ Unsafe neighborhood
- ☐ Secrets, dishonesty
- ☐ Drug or alcohol abuse
- ☐ Problems with relatives
- ☐ Fighting among family members
- ☐ Physical fights
- ☐ Infidelity
- ☐ Financial problems
- ☐ Issues regarding remarriage
- ☐ Death of a family member(s)
- ☐ Birth of a child or sibling
- ☐ Abuse or neglect
- ☐ Inadequate health insurance
- ☐ Job loss, change or job dissatisfaction
- ☐ Other concerns not listed above _____

YOUR ADOLESCENT'S STRENGTHS

At what activities do you feel your son or daughter is successful when they try? _____

_____

_____

_____

_____

What positive personal qualities would you say your son or daughter has? _____

_____

_____

_____

_____

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe) _____

_____

_____

_____

_____

INDIVIDUAL CONCERNS YOU NOTICE ABOUT YOUR SON OR DAUGHTER

Check none, mild, moderate or severe for each concern

Symptom	None	Mild	Moderate	Severe
SADNESS				
APPETITE CHANGES				
CRYING				
SOCIAL ISOLATION				
SLEEP DISTRUBANCES				
PARANOID THOUGHTS				
PROBLEMS AT HOME				
POOR CONCENTRATION				
HYPERACTIVITY				
INDECISIVENESS				
BINGING/PURGING				
LOW ENERGY				
LONELINESS				
EXCESSIVE WORRY				
UNRESOLVED GUILT				
LOW SELF WORTH				
IRRITABILITY				
ANGER ISSUES				
NAUSEA/INDIGESTION				
SPIRITUAL CONCERNS				
SOCIAL ANXIETY				
SEEING/HEARING THINGS NOT THERE				
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UNPLANNED WEIGHT GAIN/LOSS				

Symptom	None	Mild	Moderate	Severe
RACING THOUGHTS				
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GRIEF				
FEELING PANICKY				
PHOBIAS				
SUICIDAL THOUGHTS				
HEADACHES				
PAST SUICIDE ATTEMPTS				
OTHER (please specify)				

Is there anything else you would like to share: _____

_____

_____

_____

_____

_____

_____

_____

_____

Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry, or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare and support your child so that they feel safe enough to share those issues with you.

According to Missouri law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All information concerning pregnancy, sexual activity, STD's, and drug/alcohol use or abuse, regardless of the child's age.
- Any information that your child's provider believes, if released, could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.
- You should know that this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.
- In addition, there are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse and neglect.
- Finally, we recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice possible to protect him/her and encourage healthy decisions, including being open and honest with you

FAMILY INVOLVEMENT

Research indicates that family involvement is essential to the effectiveness of your adolescent's therapy. Your family is a system. When one person in the family system makes a change everyone in the family will make changes to adjust to the new situation. Your adolescent will be asked to make a lot of changes. However, there will be times when you as parent will need to make changes also. Sometimes, you may need to make changes before your adolescent can change.

Are you willing to participate in family sessions as needed? Y/N _____
Are you willing to consider recommended changes to your parenting? Y/N _____
Are you willing to make changes in your parenting when it is in the best interests of your child? Y/N _____
Will you accompany your adolescent to most or all sessions? Y/N _____ If no, how much notice will you need to schedule family sessions? _____

Parent or Guardian's Signature _____ Date _____