Social Butterfly Counseling

232 Madison Ave Wyckoff, NJ 07481
(973) 310-2417

Child/Adolescent Intake Form
(TO BE COMPLETED BY ADOLESCENT)

General Information

Name: _____ Nickname: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Please describe the reason you are seeking treatment at this time:

_____

_____

_____

Please describe how these concerns have been affecting your relationship with your family:

_____

_____

_____

Please describe how these concerns have been affecting your relationship with your friends:

_____

_____

_____

Please describe how these concerns have been affecting your functioning at school/work:

_____

_____

_____

Please describe the things you have tried that have helped you feel better:

_____

_____

_____

Please describe the things about yourself you like or feel proud of:

_____

_____

_____

Please circle the degree to which you have been experiencing each of the following MOODS, EMOTIONS, or FEELINGS:

	Not at all	Mild	Moderate	Severe
Angry				
Panicky				
Depressed				
Ashamed				
Bored				
Irritable				
Fearful				
Suspicious				
Empty				
Lonely				
Resentful				
Dependent				
Confused				
Guilty				
Nervous				
Unmotivated				
Hopeless				
Tense				
Sad				
Mistrustful				
Terrified				
Embarrassed				
Elated				
Abandoned				
Agitated				
Worried				
Helpless				
Grief				

Other (describe)

Please circle how often you have been bothered by each of the following difficulties with THINKING:

	Never	Sometimes	Often	Very Often
Concentration difficulties				
Difficulty remembering things				
Mind going "blank"				
Difficulty making decisions				
Difficulty making sound judgements				
Distractible				
Unwanted or intrusive thoughts or images				
Repetitive thoughts, images, or urges				
Thoughts of hurting or killing yourself				
Thoughts of hurting or killing someone else				
Preoccupation with death				
Other thinking concerns:				

Please circle how much you have been bothered by each of the following PHYSICAL REACTIONS:

	Never	Sometimes	Often	Very Often
Shortness of breath or smothering sensations				
Nausea, diarrhea, or other abdominal stresses				
Trouble swallowing or "lump in throat"				
Muscle tension, aches, or soreness				
Flushes (not flashes) or chills				
Dizziness or light-headedness				
Trouble falling or staying asleep				
Waking earlier in the morning than you normally do				
Sweating or cold, clammy hands				
Fatigue or loss of energy				
Decrease in appetite				

Weight loss				
Decreased need for sleep				
Numbness or tingling sensations				
Weepiness or crying				
Palpitations or accelerated heart rate				
Headaches				
Increase in appetite				
Weight gain				
Increased need for sleep				
Chest pains or discomfort				
Physical problems (impaired physical functioning, physical pain, etc.)				
Other physical reactions:				

Please circle how much you have been experiencing each of the following reactions:

	Never	Sometimes	Often	Very Often
Feeling as if things were not real				
Feeling little or no interest in things				
Feeling little or no pleasure from activities				
Having nightmares or distressing dreams				
Problems with sexual functioning				
Feeling detatched from (or as if an observer of) your own mind or body				
Feelings of inadequacy or worthlessness				
Feeling like you want to beat or harm someone				
Wanting to avoid certain people, places, things, or activities				
Social withdrawal				
Temper outbursts				
Excessively checking things, counting things, washing, or other repetitive actions you feel you must perform				

Having strange and peculiar experiences (for example: hearing voices, seeing shadows or images, etc.)				

Please place a checkmark in the appropriate box for each of the following:

Have you ever…	**Present**	**Past**	**Never**
Purposely injured yourself without suicidal intent (cut, hit, burned, etc.)			
Seriously considered attempting suicide			
Made a suicide attempt			
Considered seriously injuring another person			
Intentionally injuring another person			
Had unwanted sexual contact or experiences			
Experienced harassing, controlling, or abusive behavior from another person (friend, family member, partner, authority figure)			
Been hit, punched, slapped, kicked, or otherwise physically hurt by another person (friend, family member, partner, authority figure) with cruel or malicious intent			

Please describe your experiences with each of the following:

Substance	Amount of Use	Frequency of Use	Age at First Use	Age at Last Use	Used within past 48 hours?
Alcohol					Y N
Nicotine					Y N
Marijuana					Y N
Other:					

Over the past 6 months, how many times has each of the following happened to you because of your substance use?

	Never	Once	Twice	3-4 times	5+ times
You've gotten in trouble with your parents					
You've had problems at school or with school work					
You've had problems with friends					
You've had problems with someone you're dating/your partner					
You've been in trouble with the police					

Please place a checkmark in the appropriate box for each of the following:

How many hours per day do you spend…	**<1 /day**	**1-2 /day**	**2-3 /day**	**3-4 /day**	**4+ /day**
Using a computer					
Using a smart phone or tablet					
Watching TV or movies (including Netflix, Youtube, etc.)					
Playing video games or games on your phone/tablet					
Using social media (Facebook, Instagram, Snapchat, Twitter, Tumblr, etc.)					