

Post, Wylie and Associates
Psychological Assessment · Consulting

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Youth Counseling Intake Form

Date: _____ Referred by: _____ Person completing this form: _____

CLIENT INFORMATION

Client's Name: _____	Sex: Female / Male	Birthdate: _____
Address: _____		
Phone: _____	Alternate Ph: _____	
School: _____	Grade: _____	
Currently Living With (check and/or circle all that apply):	Number of Siblings:	
__ Biological Mother / Father / Siblings	__ Biological	
__ Adoptive Mother / Father / Siblings	__ Adoptive siblings	
__ Foster Mother / Father / Siblings	__ Foster-siblings	
__ Other Relatives _____	__ Step-siblings	
__ Friend(s)	Total # of sibs currently living with the client: ____	

GUARDIAN #1 INFORMATION

Name: _____	Sex: Female / Male	Age: _____
<input type="checkbox"/> Check if contact information same as above		
Address: _____		
Phone: _____	Alternate Ph: _____	Relationship to youth: _____
Current Relationship Status (check all that apply):	Current Custody Status:	
__ Single	__ Joint Custody	
__ In a Relationship	__ Sole Custody	
__ Married/Remarried/Living with Partner	__ Custody Evaluation in Progress/Being Contested	
__ Separated/Divorced (circle one)	__ State Custody	
__ Other _____	__ Other _____	

GUARDIAN #2 INFORMATION

Name: _____	Sex: Female / Male	Age: _____
<input type="checkbox"/> Check if contact information same as above		
Address: _____		
Phone: _____	Alternate Ph: _____	Relationship to youth: _____
Current Relationship Status (check all that apply):	Current Custody Status:	
__ Single	__ Joint Custody	
__ In a Relationship	__ Sole Custody	
__ Married/Remarried/Living with Partner	__ Custody Evaluation in Progress/Being Contested	
__ Separated/Divorced (circle one)	__ State Custody	
__ Other _____	__ Other _____	

CLIENT RESIDENCES (List most current first)

City/State:	Dates From/To:	Living With:	Reason for Moving:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY (Check **ALL** that apply & explain **CIRCUMSTANCES** in the space provided)

<input type="checkbox"/> Learning disability/Attention problems _____
<input type="checkbox"/> Depression/Anxiety _____
<input type="checkbox"/> Drug/alcohol abuse _____
<input type="checkbox"/> Physical/sexual abuse _____
<input type="checkbox"/> Mental health hospitalization _____
<input type="checkbox"/> Suicide and/or attempts _____
<input type="checkbox"/> Serious injuries/illnesses _____
<input type="checkbox"/> Legal difficulties _____
<input type="checkbox"/> Other _____

CLIENT HEALTH HISTORY (Check **ALL** that apply & explain **CIRCUMSTANCES** in the space provided)

<input type="checkbox"/> Problems during pregnancy/delivery _____
<input type="checkbox"/> Mother used cigarettes/alcohol/drugs during pregnancy _____
<input type="checkbox"/> Mother experienced illness/injury during pregnancy _____
<input type="checkbox"/> Early development problems (walking, talking, toilet training, etc) _____
<input type="checkbox"/> Serious injuries/illnesses _____
<input type="checkbox"/> Major surgeries _____
<input type="checkbox"/> Current medical conditions _____
<input type="checkbox"/> Current medications _____
<input type="checkbox"/> Smokes cigarettes _____
<input type="checkbox"/> Drinks alcohol _____
<input type="checkbox"/> Drug use _____

CLIENT PSYCHOLOGICAL HISTORY (Check **ALL** that apply & explain **CIRCUMSTANCES** in the space provided)

<input type="checkbox"/> Physical abuse _____
<input type="checkbox"/> Sexual abuse _____
<input type="checkbox"/> Verbal/emotional abuse _____
<input type="checkbox"/> Neglect _____
<input type="checkbox"/> Psychiatric diagnoses _____
<input type="checkbox"/> Suicidal thoughts/attempts _____
<input type="checkbox"/> Homicidal thoughts/attempts _____
<input type="checkbox"/> Mental health hospitalizations _____
<input type="checkbox"/> Previous counseling _____