EUGENIA SALOMON, MA, MFT

1962 NW KEARNEY STREET SUITE 204, PORTLAND, OR 97209
2105 NE CESAR E CHAVEZ BLVD, SUITE 200, PORTLAND, OR 97212

ADOLESCENT INTAKE INFORMATION

DATE _____

PERSONAL INFORMATION

NAME_____

BIRTH DATE _____ AGE _____

ADDRESS_____

CITY, STATE _____ ZIP _____

HOME PHONE _____MOBILE _____

IS IT OK TO A LEAVE MESSAGE AT: HOME ___ MOBILE ___

EMAIL _____

SIBLING: _____ AGE: _____
SIBLING: _____ AGE: _____
SIBLING: _____ AGE: _____

MOTHER'S NAME: _____
ADDRESS (CITY, STATE AND ZIP): _____
MARITAL STATUS: _____
PHONE: (H)_____ (W)_____ (C)_____
EMAIL _____
OCCUPATION_____ EMPLOYMENT STATUS_____

FATHER'S NAME: _____
ADDRESS (CITY, STATE AND ZIP): _____
MARITAL STATUS: _____
PHONE: (H)_____ (W)_____ (C)_____
EMAIL _____
OCCUPATION_____ EMPLOYMENT STATUS_____

STEP PARENT(S)/GUARDIAN(S): _____
ADDRESS (CITY, STATE AND ZIP): _____
MARITAL STATUS: _____
PHONE: (H)_____ (W)_____ (C)_____
EMAIL _____
OCCUPATION_____ EMPLOYMENT STATUS_____

History of Problem

Please describe your concerns (or, if applicable, parent's concerns regarding your child):

How long has the problem existed?

What attempts have been made to resolve the difficulties?

Have there been any significant stressors for the family: losses, births, deaths, moves, hospitalizations, or financial problems, in the last several years?

Have you had any trauma?

What are your greatest strengths?

Please check the symptoms that the adolescent is currently experiencing. Please indicate the duration, and severity.

SYMPTOM	HOW LONG	SEVERITY (0, 1, 2, 3) None, Mild, Moderate, Severe
Sadness or Depression		
Suicidal Thoughts		
Sleep Problems		
Changes in Appetite		
Weight Change		
Inability to Concentrate		
Obsessive thoughts		
Tension and Anxiety		
Panic Attacks		
Cutting		
Memory Problems		
Compulsive Behaviors		
Feelings of Hostility		
Acts of Violence		
Social Isolation		
Strange Thoughts		
Stomach Aches		
Head Aches		
Bed Wetting		
Phobias		
Other -		

Social Media/Electronics Use:

Average number of hours per week teen spends:

Playing video games, X-box, etc. _____ Types of games played: _____

Texting with friends: _____

Using other social media sites: Facebook, Instagram, etc.: _____

Watching TV/ Videos: _____

Other Child Information:

School: _____ Grade: _____ Teacher: _____

Current Grades/Academic Performance: _____

_____

History of psychiatric treatment or counseling:

_____

_____

Current or past drug or alcohol use (indicate past or present amount, frequency):

_____

Significant medical problems: _____

_____

Serious illnesses, accidents, or surgeries in the past: _____

_____

Currently prescribed medications: _____

_____

Pediatrician: _____

Psychiatrist: _____

Other Agencies/Providers Helping Your Child Currently:

_____

Family History

For parents who are divorced, please state custody arrangements. (You may be required to provide legal documentation of custody arrangements)

_____

_____

If adopted, does child know of adoption? Yes / No. Age at adoption? _____

Mother:

Significant Medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

_____

Current and past psychiatric treatment or counseling:

_____

Currently prescribed medications: _____

_____

Current alcohol/drug use (amount, how often, intoxication frequency):

_____

History of alcohol/drug use: _____

Father:

Significant Medical problems: _____

Serious illnesses, accidents, or surgeries in the past: _____

_____

Current and past psychiatric treatment or counseling:

_____

Currently prescribed medications: _____

_____

Current alcohol/drug use (amount, how often, intoxication frequency):

_____

History of alcohol/drug use: _____

Other vital family history:

_____

_____

_____

_____

_____

_____