MINNESOTA RENEWAL CENTER
Adolescent Registration Intake Form
3499 Lexington Avenue N #100, St Paul, MN 55126
Phone: 651-486-4828

INSTRUCTIONS: Thank you in advance for completing this form. The information you provide will help me to better understand your needs and those of your family. Please complete ALL information by printing clearly. Thank you.

Today's Date: ____________

Child/Adolescent Name: ______________________________ Sex: __F __M Grade in School: ______

Name of School: ______________________

Age: ____ Date of Birth: ______________

Address: ____

City: ________________ State: ___ Zip: _______

If not client, name of individual filling out form: ____

Relationship to client: __________________________________

May I leave a message at your home phone? Yes or No (circle one) Home Phone: ___________________

May I leave a message at your work phone? Yes or No (circle one) Work Phone: ___________________

May I leave a message at your mobile phone? Yes or No (circle one) Mobile Phone: ___________________

Work Hours/Best Time to Call: ____

Email: ____

How were you referred to me? ____

Presenting Problem

1. What is/are the reason(s) you are seeking therapy today? ____

____

2. Did a specific event lead to this request for service? ☐ Yes ☐ No If yes, please describe the incident. ______________________

____

3. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life as a result of attending therapy.____

____

4. How long has the problem been present? ____

5. What solutions to the problem have you tried, and what were the results? ____

____

6. How much does this problem affect your life? *(Please circle the number that best applies)*

	Not at all	A Little bit	A lot	All the time
1. Personally	1	2	3	4
2. Family life	1	2	3	4
3. Socially	1	2	3	4
4. Work	1	2	3	4
5. Academically	1	2	3	4

7. Do you make use of any community-based support groups (e.g. 12-Step Programs, social support groups, etc)? ☐ Yes ☐ No If yes, please specify: ____

8. Do you have an involvement with any of the following people or services? ☐ Yes ☐ No If yes, please circle all that apply:
Mediation County Social Worker Probation Officer Adult/Child Protection Guardian Ad Litum

Symptoms

9. Please look these items over and circle the number that best describes how these symptoms have bothered you recently.

	Not at all	Mildly	Moderately	Severely
1. Depressed, sad, or crying	1	2	3	4
2. Guilty feelings	1	2	3	4
3. Suicidal thoughts, plans, or attempt	1	2	3	4
4. Changed sleep patterns	1	2	3	4
5. Change in weight or eating habits ☐Increase ☐Decrease	1	2	3	4
6. Loss of interest or energy	1	2	3	4
7. Anxious, nervous, or panicky feelings	1	2	3	4
8. "Avoiding places" or situation	1	2	3	4
9. Repetitive thoughts or behaviors	1	2	3	4
10. Change in school performance ☐Increase ☐Decrease	1	2	3	4
11. Anger or temper problems	1	2	3	4
12. Physical problems, pain, or illness	1	2	3	4
13. Sexual worries or problems	1	2	3	4
14. Spending habits	1	2	3	4
15. Memory problems	1	2	3	4
16. Confused, disorganized	1	2	3	4
17. Hallucinations	1	2	3	4
18. Difficulty paying attention	1	2	3	4
19. Difficulty sitting still/being quiet or listening	1	2	3	4
20. Regression (previously toilet trained, bed wetting)	1	2	3	4

Mental Health History

10. Please describe any previous counseling or therapy you have had.

____

____

11. Have you engaged in self-harming behaviors such as cutting or suicide attempts?

☐ Yes ☐ No

If yes, what behavior, how many times, and when? ____

12. If applicable, please describe any previous psychiatric hospitalizations and about when they occurred.

____

____

____

13. Are you currently taking any medications to treat depression, anxiety, ADHD, or other mental health issues?

☐ Yes ☐ No If yes, please list:

Medication ____________________ Dosage ________________ Number of pills per day _____
Medication ____________________ Dosage ________________ Number of pills per day _____
Medication ____________________ Dosage ________________ Number of pills per day _____

Medical History

14. Were there any difficulties or complications during your birth? _________________________________

____

15. List any significant health problems, past or present, including surgeries and/or illnesses with the ***corresponding dates***.

____

____

____

16. Are you currently taking any other medications? ☐ Yes ☐ No If yes, please list:

Medication/Reason	**Dose and number of pills you take per day** ***(e.g. .25 mg. 3 times per day)***	**Prescribing doctor**

17. Do you have any medical or physical conditions that would interfere with their treatment here (circle one)?

☐ Yes ☐ No If yes, please explain

____

____

Family Information

18. Current Household Composition and Immediate Family. (*Please include people in your current household as well as spouse/partner and children).*

Name	Age	Relation to Child	Occupation/School	In Home?

If you live part of the time in a different household, please describe the living arrangements (i.e. weekends with father, etc)____
____

Employment/Education Information

19. Are you employed? _______________________

20. Occupation/type of work? ____

21. Are your parents employed? __________________ What occupation or type of work? ______________________________________

Chemical Use History

22. Have you or anyone else been concerned about your drug or alcohol use? If yes, please describe.
____
____

23. Is drug or alcohol use a problem in your family? ☐ Yes ☐ No If yes, please describe.
____
____

24. Have you ever had treatment in the past for any type of chemical use problems? ☐ Yes ☐ No If yes, please describe including inpatient, outpatient, and detox.
____
____

25. Are you currently in recovery? ☐ Yes ☐ No

26. Are you currently in a twelve-step program? ☐ Yes ☐ No

Resources

27. Do you have any spiritual beliefs or practices that are important to you? ☐ Yes ☐ No If yes, please explain: ________________
____
____

28. What aspects of your family's culture, heritage, or ethnicity would you like your therapist to be aware of? ____________________
____