Psychiatric Medical Associates, P.A.
6404 International Pkwy, # 1010, Plano, TX 75093
Peter Thomas, Ph.D.
Phone # 972-267-1988 Fax # 972-267-3434

PSYCHOLOGICAL INTAKE INFORMATION –Adolescent

(Please have the adolescent client fill this portion out.)

Preferred Name: _____

Gender Identity: _____

Age: _____

Sexual Orientation

☐ Heterosexual ☐ Gay/Lesbian ☐ Asexual ☐ Pansexual ☐ Bisexual ☐ Undecided ☐ Other

Ethnic Identity

☐ Caucasian/White ☐ Hispanic-American ☐ African-American ☐ Asian-American

☐ American-Indian ☐ South-Asian ☐ Other: _____

☐ Multi-Ethnic: _____

☐ Non-US Citizen: _____

Undocumented status is **NOT** reported to any government agency and will be kept confidential

• **In your own words, please describe what brings you in for counseling at this time?**

_____

_____

_____

_____

_____

• **Have you ever had feelings or thoughts of suicide?**

☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next section.

• **Do you currently feel that you don't want to live?**

☐ Yes ☐ No

How often do you have these thoughts? _____

When was the last time you had these thoughts? _____

Have you ever thought about how you would kill yourself? _____

Is there anything that would stop you from killing yourself? _____

Have you ever tried to kill or hurt yourself before? Please explain. _____

Do you have access to guns? If yes, please explain. _____

• **Past/Current Psychiatric History:**

□ Yes □ No

If YES, please answer the following. If NO, please skip to the next section.

Inpatient treatment in a psychiatric hospital □ Yes □ No

If YES, please state when, where and for what reason _____

Outpatient treatment in a partial or IOP program [] Yes [] No

If YES, please state when, where and for what reason _____

Individual, Couple, or Group Therapy [] Yes [] No

If YES, please state when, where and for what reason _____

Psychiatrist for medication [] Yes [] No

If YES, please state when, where and for what reason _____

• **Employed:** □ Yes □ No Employer: _____

□Disability

Employment History

Please provide a general description of your work and any work related stressors or issues that may be occurring at this time (Frequent job loss, been fired, inability to perform well, etc.).

_____

_____

_____

• **School History**:

School Name: _____

Home Schooled: □ Yes □No

Current Grade Level: _____

Previous grade/retentions: _____

Special Classes: _____

Current GPA: _____

Behavioral problems at school (poor attendance, suspensions, violence, oppositional etc.):

_____

_____

_____

_____

Describe your relationship with your teachers: _____

_____

_____

_____

Describe any learning problems: _____

_____

_____

_____

• **Family Information**

Please include information such as name, age, occupation etc. Please describe the relationships in your family as best you can.

Father/ Stepfather

_____

_____

Mother/ Stepmother

_____

_____

Siblings

_____

_____

Children of your own

_____

_____

Others you consider family

_____

_____

• Current Relationship

Are you currently:

[] Single [] Married (How long: _____) [] In a Committed Relationship

[] Widowed [] Separated [] Divorced [] Living together [] Engaged

[] Never Married

• What was the role of Religion in your life?

_____

_____

• Drug Use History

This information is confidential.

□ Marijuana □ Alcohol □Opiates/Heroin □ Methamphetamines/Cocaine

□Prescription drugs □Inhalants □ Ecstasy □ Prescription Medication

□ Hallucinogens □ Synthetic Drugs □Other: _____

Please indicate how long and how often you have been using any of the above:

_____

_____

Please indicate any consequences you think you may have had as a result of your drug use (arrest, overdose, loss of relationships, work/school problems, withdrawal etc.):

_____

_____

Psychiatric Medical Associates, P.A.
6404 International Pkwy, # 1010, Plano, TX 75093
Peter Thomas, Ph.D.
Phone # 972-267-1988 Fax # 972-267-3434

Have you ever been treated for alcohol or drug abuse? ☐ Yes ☐ No

If yes, when and where?

_____

Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No

• Medical History

Please describe anything you think I should know about your medical history such as head injury, cardiovascular problems, significant illnesses, stroke, gastrointestinal problems, tic, etc.

_____

_____

_____

• What goals would you like to accomplish in coming to treatment?

_____

_____

_____

Your confidentiality and the confidentiality of your adolescent are of upmost concern. However, please be aware that, as a psychologist, I am required by the State of Texas to report any suspicion of abuse towards a child or elderly adult. If you have any questions about limits to confidentiality, please speak with me directly.

I have read, understood, and agreed to the policy listed above for Psychiatric Medical Associates.

_____ _____

Signature Date

_____

Printed Name

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No			
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes		☐ No			
	25.	Have you EVER tried to kill yourself?	☐ Yes		☐ No			