

**Peek Counseling, PLLC**  
**INTAKE FORM FOR ADOLESCENT (15-17 Years Old)**

The information you provide in this intake form may be confidential; however, certain otherwise confidential information may be shared as required by law. You are not required to supply the information contained in this Intake Form. However, the more information you provide, the better Katie Bisbee-Peek with Peek Counseling, PLLC is able to assess your mental health needs. Please provide as much information as possible.

This intake form should be filled out by everyone who is fifteen (15) years of age to seventeen (17) years of age. Parents or Legal Guardians should only help fill out this form if the client consents. The information parents or legal guardians share in this form and the information the minor client shares in this form shall not be disclosed unless Katie Bisbee-Peek with Peek Counseling, PLLC determines it is in the best interest of the minor child to disclose such information in accordance with C.R.S. § 27-65-103 and the Department of Regulatory Agencies' Rules and Regulations.

Any request or authorization in this form to contact a Third Party, such as a medical doctor, will require a separate Authorization for Release of Information.

**Client Information:**

Client's Name: \_\_\_\_\_

Gender:  Male  Female

Client's Birthdate: \_\_\_\_\_

Client's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

May Katie Bisbee-Peek with Peek Counseling, LLC contact you at this address:  YES  NO

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

May Katie Bisbee-Peek with Peek Counseling, PLLC contact you at all the above telephone numbers provided:  YES  NO

May Katie Bisbee-Peek with Peek Counseling, PLLC leave a voice message at all the above telephone numbers provided:  YES  NO

Email Address: \_\_\_\_\_ Do you share this email address with anyone else?  
If so please list who else shares the email address: \_\_\_\_\_

May Katie Bisbee-Peek with Peek Counseling, PLLC contact you at the above email address:  
 YES  NO

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**\*\*Please be aware there is a risk that an unintended third-party may access information shared by electronic transmissions such as email and/or cell phones. By allowing Katie Bisbee-Peek with Peek Counseling, PLLC to contact you by email you are consenting to receive electronic communications and understand the risks involved. Katie Bisbee-Peek with Peek Counseling, PLLC cannot guarantee that confidential information shared using electronic communications will remain confidential.**

What is your preferred method of communication:  Telephone (H)  Telephone/Text (C)  
 Email

Family Information:

Are your parents:  Married or Civil Union  Separated  Divorced  Living Together

If your parents are no longer together, are either of your parents remarried:  YES  NO

Please list your Stepmother and/or Stepfather's Name and telephone number:

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May Katie Bisbee-Peek with Peek Counseling, PLLC contact any Stepmother and/or Stepfather:

YES  NO

Mother's Name: \_\_\_\_\_

Mother's Telephone: \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

Do you live with your Mother:  YES  NO

If yes, do you live with her  Full-Time  Part-Time

May Katie Bisbee-Peek with Peek Counseling, PLLC contact your Mother:  YES  NO

Father's Name: \_\_\_\_\_

Father's Telephone: \_\_\_\_\_

Father's Address: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Do you live with your Father:  YES  NO

If yes, do you live with her  Full-Time  Part-Time

May Katie Bisbee-Peek with Peek Counseling, PLLC contact your Father:  YES  NO

Do you have any siblings:  YES  NO      How many? \_\_\_\_\_ Ages: \_\_\_\_\_

Do you live with all your siblings:  YES  NO

If no, who do your other siblings live with:

Are there any other persons that live in your home with you:  YES  NO

If yes, please list their names and ages, and any relationship to you:

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Emergency Contact Information:

In case of an emergency, Katie Bisbee-Peek with Peek Counseling, PLLC may be required to contact someone on your behalf. Please list your emergency contact below, which Katie Bisbee-Peek with Peek Counseling, PLLC may contact on your behalf. Katie Bisbee-Peek with Peek Counseling, PLLC will share the minimum amount of information necessary with your emergency contact should he or she need to be contacted.

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Client's Hobbies and Interests:

Do you work:  YES  NO

If yes, please state where you are employed: \_\_\_\_\_

Do you play any sports or musical instruments:  YES  NO

If yes, please list what sports and/or musical instruments you play:

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Please list any other hobbies or interests that you have:

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How do you normally spend your day? What does a typical day look like for you?

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What school do you attend and what grade are you in:

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What is your favorite subject taught in school:

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Primary Care Physician Information:

In order to provide you with continuous and congruent care, Katie Bisbee-Peek with Peek Counseling, PLLC may need to contact your primary care physician. Any contact that Katie Bisbee-Peek with Peek Counseling, PLLC may have with your Primary Care Physician will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Please Provide the Date of Your Last Physical: \_\_\_\_\_

May Katie Bisbee-Peek with Peek Counseling, PLLC contact your physician:  YES  NO

Please list any medication you are currently taking (if you are not currently taking any medications, please state that you are not currently taking any medications):

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Please list any current physical illnesses, issues, and/or ailments you have (if you do not currently have any physical illnesses, issues, and/or ailments, please state so):

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Previous/Current Mental Health Provider(s):

In order to provide you with continuous and congruent care, Katie Bisbee-Peek with Peek Counseling, PLLC may need to contact your previous or current Mental Health Provider. Any contact that Katie Bisbee-Peek with Peek Counseling, PLLC may have with your previous or current Mental Health Provider will require you to sign an Authorization for Release of Protected Health Information and Confidential Information.

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Please Provide the Date of Your Last Session: \_\_\_\_\_

May Katie Bisbee-Peek with Peek Counseling, PLLC contact your previous or current Mental Health Provider:  YES  NO

Are you currently in counseling with the above listed mental health provider:  YES  NO

Have you ever sought counseling before:  YES  NO

If yes, please list your reason(s) (if you are currently seeing another mental health provider, please list the reason(s) here as well):

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Client's Mental Health:

Please tell us why you are seeking counseling and describe any issues/problems that led you to seek counseling.

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How have you dealt with these issues/problems in the past:

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Please list any past or current issues that may affect your mental health:

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Have you ever been, or are you currently, suicidal:

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Have you ever attempted to commit suicide:

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Has anyone in your family ever attempted or committed suicide:

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Have you used, or do you currently use, alcohol, inhalants, nicotine products, marijuana, or any illegal drugs (if so, please indicate which ones):

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Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate):  YES  NO

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Have you ever gotten in trouble at school? If so, please describe the circumstances and what happened afterwards:

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Are you currently involved in any civil or criminal legal proceedings:  YES  NO

If yes, please state the circumstance(s):

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Are there any weapons available or unlocked in your home:

YES  NO  Prefer not to Answer

If yes, please list the weapon, where it is located, and who it belongs to:

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Do you have a preoccupation with weapons, violence, killing, or fire:

YES  NO  Prefer not to Answer

If yes, please describe:

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Is there anything else you would like Katie Bisbee-Peek with Peek Counseling, PLLC to know:

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What would you like to accomplish through therapy and/or what goals would you like to achieve?:

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Client Affirmation:

By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## Checklist Of Concerns:

**Client Name:** \_\_\_\_\_

Please mark all of the areas of concern below that apply to you. You may add a note or details in the space next to the concerns checked.

CONCERN	NOTES	NOW	IN THE PAST
Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals			
Aggression, violence			
Alcohol use			
Anger, hostility, arguing, irritability			
Anxiety, nervousness			
Attention, concentration, distractibility			
Career concerns, goals, and choices			
Childhood issues (your own childhood)			
Codependence			
Confusion			
Compulsions			
Custody of children			
Decision-making, indecision, mixed feelings, putting off decisions			
Delusions (false ideas)			
Dependence			
Depression, low mood, sadness, crying			
Divorce, separation			
Drug use—prescription medications, over-the-counter medications, street drugs			
Eating problems—overeating, undereating, appetite, vomiting, (see also “Weight and diet issues”)			
Emptiness			
Failure			
Fatigue, tiredness, low energy			
Fears, phobias			
Financial or money troubles, debt, impulsive spending, low income			



Friendships			
Gambling			
Grieving, mourning, deaths, losses, divorce			
Guilt/Shame			
Headaches, other kinds of pains			
Health, illness, medical concerns, physical problems			
Inferiority feelings			
Interpersonal conflicts			
Impulsiveness, loss of control, outbursts			
Irresponsibility			
Judgment problems, risk taking			
Legal matters, charges, suits			
Loneliness			
Memory problems			
Menstrual problems, PMS, menopause			
Mood swings			
Motivation, laziness			
Nervousness, tension			
Obsessions, compulsions (thoughts or actions that repeat themselves)			
Oversensitivity to rejection			
Pain, chronic			
Panic or anxiety attacks			
Perfectionism			
Pessimism			
Procrastination, work inhibitions, laziness			
Relationship problems (with friends, with relatives, or at work)			
School problems			
Self-centeredness			
Self-esteem			
Self-neglect, poor self-care			
Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")			
Shyness, oversensitivity to criticism			
Sleep problems—too much, too little, insomnia,			

nightmares			
Smoking and tobacco use			
Spiritual, religious, moral, ethical issues			
Stress, relaxation, stress management, stress disorders, tension			
Suspiciousness, distrust			
Suicidal thoughts (You or a relative)			
Temper problems, self-control, low frustration tolerance			
Thought disorganization and confusion			
Threats, violence			
Weight and diet issues			
Withdrawal, isolating			

Other concerns or issues:

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**Client Affirmation:**

By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**\*\*OPTIONAL\*\* For the Parent or Legal Guardian:**

In Colorado, an adolescent that is fifteen (15) years old or older may consent to receive mental health services without a parent or legal guardian's consent. You, as a parent or legal guardian, are not required to fill out the below information; however, by providing this information your minor child's therapist may be able to better assess your minor child's mental health needs.

What brings you and your minor child in today? What do you hope for your child to accomplish in counseling?

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Does your family have a history of mental illness such as depression, anxiety, drug/alcohol abuse, addictions, eating disorders (if yes, please indicate):  YES  NO

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Are there weapons in your home:  YES  NO  PREFER NOT TO ANSWER

If yes, please list the weapon, who owns the weapon, where it is located, and whether its secured:

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Are there any restraining orders that Katie Bisbee-Peek with Peek Counseling, PLLC should be aware of:  YES  NO

If yes, please provide a copy of the restraining order and describe the circumstances under which it was ordered):

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If you are divorced or separated, please list who has decision-making authority and custody over the minor child. Please include a copy of the court custody order or custody agreement.

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Who will be dropping off and picking up the minor child at Peek Counseling, PLLC:

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\*Does Katie Bisbee-Peek with Peek Counseling, PLLC have permission to discuss administrative details, such as appointments and scheduling with this person:  YES  NO

A separate Authorization for Release of Information will be required to discuss any details with the above named individual.

Is there anyone that should **NOT** pick up the minor child at Peek Counseling, PLLC:

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Financial Information:

1. Do you intend on a third-party (another person) paying for counseling services:  YES  NO  
If yes, please provide the following information:

Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

3. Do you intend on paying for counseling services for your minor child on your own:  
 YES  NO

Please be aware that anyone over the age of fifteen (15) years old must consent to receive mental health services. As such, your minor child must sign this intake form and Katie Bisbee-Peek's Disclosure Statement. It is within Katie Bisbee-Peek with Peek Counseling's sole discretion to advise you of the services given to or needed by the minor child and/or provide you with a treatment summary.

Parent or Legal Guardian Affirmation:

By signing this Intake Form, I certify that all the information I provided is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Adolescent Client's Signature

\_\_\_\_\_  
Date