



## Adolescent Client Intake Form

<b>Name</b>			
<b>Address</b>			
<b>DOB</b>			
<b>Guardians</b>			
<b>Guardians' Phones</b>			
<b>Occupations</b>			
<b>Marital Status</b>	Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Cohabiting <input type="checkbox"/> Divorcing <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other <input type="checkbox"/>		
<b>Family Composition</b>	<b>Name</b>	<b>Relationship</b>	<b>Age</b>
<b>Are both parents aware of and in agreement to their child attending counselling?</b>		Yes	No
<b>Notes:</b>			



## Adolescent Client Intake Form

School Name	
Class/Year	
Teacher/Principal	
Phone	
Academic Performance	

GP Name		
Phone		
Permission to Contact GP	Yes	No

Engaged with any other Services?	Yes	No
Details:		
Permission to Contact	Yes	No
Attended counselling before?	Yes	No
Details:		
Currently taking medication?	Yes	No
Details:		

Referred by:	
Notes:	



## Adolescent Client Intake Form

<b>Relationship with Parents</b>	
<b>Relationship with Siblings</b>	
<b>Relationship with Peers</b>	
<b>Best Friend</b>	
<b>Personality</b>	
<b>Strengths</b>	
<b>Weaknesses</b>	
<b>Hobbies &amp; Interests</b>	
<b>Sleep Pattern</b>	
<b>Appetite</b>	
<b>Recent Losses</b>	



## Adolescent Client Intake Form

<b>Reason For Seeking Counselling</b>	
<b>What would you like to see happen as a result of counselling?</b>	
<b>Is the child open to attending?</b>	

<b>Comments:</b>
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## Adolescent Client Intake Form

### File Copy

#### Confidentiality Agreement:

I understand that confidentiality will be upheld and respected. However, I am aware of and accept the following limits to confidentiality:

- If my therapist deems me a risk to myself I understand and agree that they will inform my next of kin to ensure my safety and wellbeing .
- If my therapist deems me a risk to others I understand and agree that they may inform my next of kin and contact the relevant authorities in order to ensure my wellbeing and that of the public.
- Any information disclosed in relation to child abuse and/or any child welfare concerns will be reported to the relevant authorities.
- My case may be discussed during Therapist supervision.

Signed Client:

Signed Guardian/ Guardians:

#### Consent :

I consent and agree to my child attending counselling

Signed Guardian/ Guardians:

#### Fee Agreement:

- The agreed fee per session is €
- The fee is payable at the end of each session
- 24 hours' notice is expected for appointment cancellation
- Cancellations within 24 hours of appointment time will incur the full fee
- Non-attendance will incur full fee
- Session duration is 45 minutes from your appointed time. It is not possible to extend the session beyond the allocated time in the event of late arrival.

Signed Guardian/ Guardians:

<b>Therapist</b>	Signed:	Date:
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# Adolescent Client Intake Form

## Client Copy

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Signed Guardian/ Guardians:

<b>Therapist</b>	Signed:	Date:
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