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Hill City, SD 57745
Office: 605.390.8791

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Rapid City, SD 57702
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Young Adult Intake

A. Identification

Your name:_____________________________________ Today's date: ___/___/___ Your age: ______
What name do you prefer to be called: ______________ Gender preference: ____ Pronoun Preference: ____

B. Health

How tall are you?_______ How much do you weigh? _______ What do you think is your ideal weight? _____
What kind of exercise do you do? __________________________________ How often? _________________

Which of these have you used in the last year? ___Tobacco ___Alcohol ___Marijuana
___Ritalin/other stimulants ___Steroids ___Hormones ___Emetics (to vomit) ____Laxatives
___Other chemicals: ____

C. Family

Main caregiver: _____________________________ Main caregiver: __________________________________
Are these your: ___birth parents? ___adoptive parents? ___stepparents? ___Other?_________________
How would you describe their relationship? ____
Do your caregivers have legal issues? ____
What kinds of problems are you having with:
Your parents/stepparents/partners of parents? ____
Your siblings (or stepsiblings)? ____
Other members of your family? ____
What are your responsibilities at home? ____
How do your caregivers discipline or punish you? ____
How important is religion/spirituality to your family? ___Highly ___Not too much ___Not important
How important is religion to you? ___Highly ___Not too much ___Not important

D. School

Which school do you go to? _________________________________ Grade level/year: ___________________
Which subjects are hardest for you? ____
Are you having problems in school? If so, describe: ____
What are you plans after you graduate? ____

E. Work

Do you work? ___No ___Yes If yes, how many hours a week? ________
What do you do? _______________________________ Where? ______________________________________
Are you having problems at work? If so, describe: ____

F. Special skills or talents

What are your hobbies? ____
What sports do you play? ____
What do you enjoy doing most? ____
What are your greatest accomplishments and strengths? ____

G. Your friends and social activities

Names of best friends	Age	Gender	What do you do together?

Do you party? ___Never ___Some ___Often. If so, when and where?________________________________
____

Do you have a cell phone? ___No ___Yes
How many hours a day do you spend online? ___ Watching TV? ___ Listening to music? ___ What kind of music do you like best? ____
Circle any oof these you use: texting, email, Facebook, Instagram, Twitter, other (specify):____________________

H. Concerns

Would you like information or answers in any of these areas: ___Sex ___Body changes ___Birth control
___Alcohol ___Drugs (if so, which?)____
___Adult relationships ___Love ___Training and jobs ___Other:___________________________________

What worries or upsets you?____
Why do you think you are here? Please tell me in your own words.____________________________________
____

What would you like to see happen or change because of this counseling? ______________________________
____
What would you like me to let your parents know? ____
Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?_______
____

Your signature: ____
____