Patient Label

PROVIDENCE Medical Group
Child and Adolescent Psychiatry Clinic
1511 Division St., Suite 101, Oregon City, OR 97045
(Phone) 503.722.3705 (Fax) 971.282.0132

New Patient Adolescent Intake Form

To be completed by patient (12-17 years old)

Please fill it out as completely as you can. We appreciate your time and input! You will provide very helpful information to the provider who will be meeting with you. Bring the completed forms to your first appointment.

1. Who made the decision to set up this appointment? _____
2. What did your parents/caretaker tell you about this appointment? _____
   _____
3. Do you think it's important for you to see us? ☐ Yes ☐ No
   a. If yes, what issues have you been having lately? _____
      _____
   b. What have you done to try to resolve these issues? _____
      _____
4. What would you like to be better in your life? _____
   _____
5. What are your parents/caretaker doing for you that is helpful? _____
   _____
6. What could your parents/caretaker do to be more helpful? _____
   _____
7. Do you take part in after-school activities (sports, scouts, theater, music, etc)? ☐ Yes ☐ No
   a. If yes, what are these activities and how often are you involved? _____
      _____
8. How would your friends describe you? _____
   _____
   a. Do you agree with how your friends see you? ☐ Yes ☐ No
9. How do you see yourself? _____
   _____
10. What are you good at? _____
    _____
11. What's going well in your life? _____
    _____
12. Are you dating? ☐ Yes ☐ No
    a. If yes, how long have you been in this relationship? _____
       _____
13. What would you like to be when you grow up? _____
    _____

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14. If you could have three wishes that would improve your life, what would they be?
    a. _____
    b. _____
    c. _____
15. How much time do you spend on the following each day?

Activity	Time Spent	Activity	Time Spent
Video/Computer Games		With friends	
Homework		Alone	
Social Media (I.E. YouTube, Facebook, Instagram, etc.)		With Family	
TV		At a job	

    a. Do your parents/caretaker express concern about the amount of time you spend on any of the above?
    ☐ Yes ☐ No

16. Check all that apply:

☐ In the past, I have used more than one chemical (drug or alcohol) at the same time to get high
☐ I sometimes avoid family activities so I can use drugs or alcohol
☐ I have a group of friends who use drugs or alcohol
☐ I use drugs or alcohol to improve my emotions, such as when I feel sad, depressed, or anxious

17. Please check off all chemicals that you use:

Type	How often (times per day or week)	Amount used	What does it do for you?
☐ Alcohol			
☐ Tobacco			
☐ Caffeine			
☐ Marijuana			
☐ Vape			
☐ Other (ecstasy, meth, inhalants, cocaine, etc.)			
☐ Non-medical use of prescribed or over-the-counter drugs (Vicodin, Percocet, Ritalin, etc.)			

18. Do you believe you have a problem with chemicals? ☐ Yes ☐ No
19. How would you know if you had a problem with them?_____
_____
20. Have you shared the information on this packet with your parents/caretaker? ☐ Yes ☐ No