

PMG Child & Adolescent Psychiatry Clinic
Adolescent New Patient Intake Form
To be completed by patient (12-17 years old)

Please fill it out as completely as you can. You will provide very helpful information to the psychiatrist 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. If you could have three wishes that would improve your life, what would they be?

- a. _____
- b. _____
- c. _____

14. What would you like to be when you grow up? _____

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 or depressed

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?
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Tobacco			
<input type="checkbox"/> Caffeine			
<input type="checkbox"/> Marijuana			
<input type="checkbox"/> Other (ecstasy, meth, inhalants, cocaine, etc.)			
<input type="checkbox"/> 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