Sarah Souder Johnson, MEd, LPCC
Anxiety Therapy Group for Teens

# Teen Anxiety Therapy Group Intake

*This form may seem long, but the information on it will help me to better understand you. The information on this form is confidential unless it has to do with hurting yourself or someone else.*

**Adolescent Demographic Information**

Name:_______________________________________________________

Address:_____________________________________________________

____________________________________________________________

Gender:_________________ Age:____________ Date of Birth:_____________

Home Phone:__________________________________ Is it okay to leave a message: Yes/No (please circle one)

Client Cell Phone:________________________________ Is it okay to leave a message: Yes/No (please circle one)

Parent Cell Phone: _______________________________Is it okay to leave a message: Yes/No

Parents or Legal Guardians:__________________________________________________

With whom do you live?_____________________________________________________

How did you hear about our group? ____________________________________________

Do you have siblings? If yes, how many? Please list their names and ages:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Were you adopted? (Please circle) Yes/No
If you answered "Yes" to the above, at what age were you adopted?________________

Have you ever been in foster care or a similar living arrangement? (Please circle) Yes/No
If you answered "Yes" to the above, at what ages were you in care________________

What school do you go to?_______________________________________Grade:________

Do you like attending this school? Are you having any difficulties?
____________________________________________________________________________

____________________________________________________________________________

Religious Affiliation:__________________________________

Religious/spiritual traditions you would like me to know about:

____________________________________________________________________________

____________________________________________________________________________

What are your hobbies/interests?
____________________________________________________________________________

____________________________________________________________________________

**Assessment:**
Please check any/all of the symptoms you are having:

| Depression | | Feeling Hopeless | |
|---|---|---|---|
| Extreme Sadness | | Problems Getting Along with Family | |
| Trouble Concentrating | | Change in Sleeping Habits | |
| Memory Problems | | Lack of Energy | |
| Change in Eating Habits | | Weight Changes | |
| Extreme Happiness | | Feeling Tearful | |
| Trouble going to school | | Problems with Getting Along with Friends | |
| Lack of Enjoyment in Usual Activities | | Feeling Stressed | |
| Obsessions/Compulsions | | Easily Irritated | |
| Feeling Fearful | | Feeling Guilty | |
| Physical Complaints of Pain | | Feeling Worried or Anxious | |
| Problems with Anger | | Sudden Feelings of Panic | |
| Unusual Dreams | | Muscle Tension | |
| Drug or Alcohol Use | | Acting Violent | |
| Thoughts of Hurting Yourself or Others | | Thoughts of Killing Yourself or Others | |

Do you currently see another therapist? (Yes/No) If so, what is their name?

_______________________________________________________________________________

_______________________________________________________________________________

Have you been diagnosed with a Learning Disorder? If so, which one(s)?

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**History:**
Have you ever experienced any critical events or an event that you consider traumatic?

_________________________________________________________________________

_________________________________________________________________________

**Current Support Group:**
What would you like to get out of this group?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

What else would you like me to know about you at this time?

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

**Parents:**
Please feel free to add anything you wish below (additional information you would like the therapist to know, goals you have for your teen, etc.).

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Thank you for taking the time to complete this form. This information will be very helpful to the therapist and your group therapy/your teen's group therapy.