JENNIFER SIGMAN, LMFT
ORLANDO THERAPY PROJECT

ADOLESCENT INTAKE

1. Name _____
   Address _____
   City, State, ZIP _____
2. Cell phone (_____) _____
3. E-mail _____
4. Date of Birth _____ Age _____
5. Grade in School _____
6. Name of School _____
7. What bothers you about school?

   _____
   _____
   _____
8. What bothers you at home with your family?

   _____
   _____
   _____
9. What problems are you having with your friends?

   _____
   _____
   _____
10. What problems have you kept to yourself?

    _____
    _____
    _____
11. What do you like or not like about yourself?

    _____
    _____
    _____
12. Who do you talk to when something bothers you?

    _____
    _____
    _____
13. What's the main reason you're seeking therapy?

    _____
    _____
    _____

Thank you.