ADOLESCENT INFORMATION FORM

This page is to be completed by your parent. You may complete all other pages.

Client Name:_____ Gender __M __F Date of Birth:_____ Age:_____

Client's Address_____ Phone_____

Father:_____ Address_____ Phone_____

Mother:_____ Address_____ Phone_____

PRESENTING PROBLEMS

Why are you seeking services for your teen at this time?_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____ Physician's Phone:_____

Current medications being taken:

1)_____ Freq _____ Start Date_____ Purpose_____

2)_____ Freq _____ Start Date_____ Purpose_____

3)_____ Freq _____ Start Date_____ Purpose_____

4)_____ Freq _____ Start Date_____ Purpose_____

Date of last medical evaluation:_____ Date of next appointment:_____

Has your child ever been hospitalized for medical or psychiatric reasons? ___NO ___YES

Hospital	Mo/Yr	Reason

Describe any important medical history, chronic ailments, or other health problems your child has experienced:_____

Describe any other health/mental health problems about immediate family members and close relatives, including chronic ailments:_____

DEVELOPMENTAL HISTORY

Pregnancy Complications: No____ Yes_____

Early Childhood Complications: No____ Yes_____

Developmental Milestones:	Slowed	Average	Fast	Comments
Crawling				
Walking				
Talking				
Toilet training				

This and the following pages are to be filled out by you, the client.

SCHOOL AND FAMILY HISTORY

Do you experience any academic or behavioral problems while in school? No____ Yes____ Explain_____

_____

What school are you currently attending? _____Grade_____ GPA_____

Who do you count on for support? _____

_____

Please check all information which applies to your biological parents:

MOTHER'S Name_____ FATHER'S Name_____

____ deceased ____ deceased

____ married ____ married

____ divorced ____ divorced

____ remarried ____# of times ____ remarried ____# of times

With whom do you live? Mother____ Father____ Stepmother____ Stepfather____ Guardian ____ Grandparent____

Do you consider someone else (step-parent, grandparent, etc.) to be your "real" parents? If so, whom? _____

_____

List first names and ages of your brothers & sisters, stepbrothers/stepsisters:

Name	Age	Relationship	Lives with:

Others living in the home with you:

Name	Age	Relationship

How do you get along with your:	Good	Fair	Poor	No relationship
Mother:				
Father:				
Step mother:				
Stepfather:				
Brothers/Sisters:				

Describe any relationship problems:_____

_____

Describe any problems that have occurred in your family relating to:

Violence/Legal Problems:_____

_____

Alcohol/drug abuse:_____

_____

Family sexual/physical/emotional abuse:_____

_____

MENTAL STATUS

Please check any of the following that describe what you have experienced or how you have been feeling lately:

___sadness	___sleeping more	___anxious	___body pains
___crying more	___sleeping less	___nervousness	___gaining weight
___loss of interest	___irritable	___worried	___losing weight
___loss of pleasure	___jealous	___panic attacks	___restricting food intake
___hopeless	___resentful	___racing heart	___inducing vomiting
___helpless	___angry	___trouble breathing	___confusion
___worthlessness	___aggressive behavior	___frightened	___suspicious of others
___guilty	___feeling tired	___repetitive thoughts	___unusual beliefs
___ashamed	___excess energy	___repetitive behaviors	___visions
___withdrawal	___eating more	___stomach pains	___voices
___mood swings	___eating less	___headaches	___cutting

Describe any other troubling feelings you have had: _____

_____

Have you recently considered suicide? ___NO ___YES Describe:_____

Have you ever considered suicide in the past? ___NO ___YES Describe:_____

Have you ever attempted suicide ? ___NO ___YES Describe:_____

_____

Have you had any thoughts of harming others? ___NO ___YES Describe:_____

Have you ever seriously harmed or abused someone else in the past? ____NO ___YES Describe: _____

_____

Have you ever purposely harmed animals? ___NO ___YES Describe_____

LEVEL OF FUNCTIONING

List or describe any current stressors or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or school or completing daily tasks, and problems with family members, etc.):_____

_____

_____

What activities or hobbies do you participate in? _____

_____

What do you like to do for fun or entertainment?_____

_____

_____

Do you participate in regular exercise? ___YES ___NO Describe:_____

Do you have a best friend? ___NO ___YES_____

Do you have a boyfriend or girlfriend? ___NO ___YES _____

Has anyone ever touched you inappropriately or asked you to participate in sexual activity? ___NO ___YES Describe:_____

_____

_____

USE OF SUBSTANCES

Do you drink alcohol? ____NO ____YES If no, did you drink previously? ____NO ____YES If yes to either, please describe what you typically drink, how often, and how much:_____

_____

Have you used any drugs or intoxicating/illegal substances? ____NO ____YES If yes, please list what you have used and how often_____

_____

If yes, did you stop? ___NO ___YES When?_____

Do you smoke cigarettes? ___NO ___ YES Use other tobacco: ___NO ___YES If so, what?:_____

OTHER ITEMS

How do you feel about participating in therapy?_____

_____

_____

Do you have any concerns about confidentiality in counseling? ___NO ___YES Describe_____

_____

_____

Is there any other information regarding you or your family that you would like to share that is not covered on this form? You may also use this space to complete earlier responses.

_____

_____

_____

_____

_____

_____

Please list your goals for counseling at this time (What you would like help for or to see change that we can address in counseling):_____

_____

_____

_____

How were you referred to Dr. Christy? ___Parents ___Insurance ___Pastor ___Physician ___Family member ___Friend ___Other Therapist ___Phonebook ___School ___Website ___Psychology networking site

_____ _____

Signature Date