This information is personal & confidential and will only be shared between you and your counselor.

Teen/Adolescent History

Name: _____ **Date of Birth:**_____/_____/_____

Who has custody? _____

Are there any outside agencies involved? Y/N **If yes please explain who and why:**

_____

List people who live in the same home:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Marital Status of parents (circle): Married Separated Divorced Widowed Never Married

To what adult are you closest (mom, dad, grandparent, etc.): _____

Has there been any recent life changing events/disruptions? Y/N **Please Explain:**

_____

_____

History of problem

Is your child experiencing now or have they experienced any of the following in the past 6 months:

____ Appetite change (more/less)
____ Difficulty sleeping
____ Fatigue/loss of energy
____ Difficulty concentrating/making decisions
____ Low self-esteem
____ Recurrent thoughts of death/suicide
____ Recurrent thoughts or acts of self-harm
____ Panic attack
____ Muscle tension
____ Fear of losing control
____ Anxiousness/nervousness
____ Wetting/bowel accidents
____ Academic problems: Grades Social Other
____ Bullying: If so, how:_____
____ Family Concerns: If so, how: _____

____ Loss of interest in activities/things
____ Depressed mood
____ Irritability/anger/agitation
____ Significant weight loss or gain
____ Feeling worthless
____ Feeling hopeless
____ Feeling keyed up or on edge
____ Excessive worry
____ Heart palpitations/racing
____ Nightmares
____ Day dreaming
____ Difficulty making friends

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Describe what brings you here today: _____

_____

_____

When did you first think there might be a problem?

_____

_____

Is the problem worse at certain times, situations, places?

_____

_____

Have you noticed any changes in the pattern you:

Eat: _____

Sleep: _____

Have you ever?

Set fires___
Ran away___
Stolen/shoplifted___
Acted out sexually___
Abused drugs/alcohol___
Been cruel to animals___
Physically assaulted anyone___

School History

School: _____ **Grade:**_____

How are your grades in school? _____

Has there been a noticeable change in grades? Y/N **If yes, when?** _____

Have you ever been suspended or expelled? Y/N **If yes, when?** _____

How do you get along with peers? _____

How many schools have you attended during the past three years? _____

Previous Mental Health Services

Have you received counseling services before? Y/N **If yes, when?** _____

Where? _____ **Reason for discontinuing?** _____

Have you had any psychiatric hospitalizations? Y/N **If yes, when?** _____

Where? _____ **Reason?** _____

Medical History

Your personal physician: _____

Are you on any prescription medications? Y/N

If yes, please list:

Medication (and dose)	Condition	Prescribing Doctor
_____	_____	_____
_____	_____	_____

Have you started puberty? Y/N **If yes, approx. when did it start?** _____

Have you been sexually active? Y/N **If yes, was birth control used?** Y/N

Have you ever used (check any that apply):
Cigarettes___ Alcohol___ Marijuana___ Inhalants___ Street Drugs ____

Are you currently doing any of these? _____

Family / Social History

If you do not live with both parents, what is the visitation arrangement with parent not in home?

_____

Have you ever lived with any other person beside parent? If yes, please explain (include relationship, dates):

_____

_____

Have you ever been abused physically, sexually, or emotionally? If yes, please explain:

_____

_____

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Have you witnessed violence in the home or had a severely traumatic experience? If yes, please explain:

_____

_____

_____

How are you disciplined? _____

Has this method been effective? _____

What chores are you responsible to complete? _____

Do you usually accomplish chores? _____

Please list your strengths: _____

_____

Please list your weaknesses: _____

_____

How do you get along with your parents? _____

Thank you for your time.

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Read, sign and accept the policy below:

If parents are divorced or separated, we need to have the appropriate court documents in the teen's records showing who has custody and who is responsible for seeking medical care/counseling if it is so indicated in the court document.

This office does not get involved in custody and financial disputes. The person signing for the responsibility for the teen will be the person indicated as the one financially responsible for services rendered by our counselors. Any financial arrangements made between divorced/separated parents are to be handled between the parents.

I, (Parent/Client/Guardian), understand the above statements and agree that this is for the best interest of the Client.

I, (Parent/Client/Guardian), authorize the individual(s) listed below to make appointments for and/or bring the Client to the appointments on my behalf.

Print Name	Relationship
Print Name	Relationship
SIGNATURE OF PARENT/CLIENT/GUARDIAN	DATE