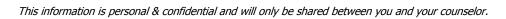


Teen/Adolescent History

ame:		Date of Birth://		
Who has custody?				
Are there any outside agencies involved? Y/N 1	If yes pleas	e explain wh	o and why:	
List people who live in the same home:				
Name	Age	Relatio	-	
Marital Status of parents (circle): Married Sepa				
		_		
To what adult are you closest (mom, dad, grand	lparent, etc	.):		
History of pr				
Is your child experiencing now or have they ex	perienced a	ny of the foll	owing 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	De Irr Sig Fe Fe Fe He Nig Da Dif	ss of interest in pressed mood itability/anger, inficant weigheling worthlesseling hopelesseling keyed upcessive worry art palpitation ghtmares y dreaming ficulty making	nt loss or gain s o or on edge s/racing	
Bullying: If so, how:				
Family Concerns: If so, how:				



Describe what brings you here t	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 i				
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 cha	inge 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 peer	rs?			
How many schools have you attended during the past three years?				
Previous Mental Health Services				
Have you received counseling so	ervices hefore? Y/N If ves. when?			





Where? Reason for discontinuing?					
Have you had any psychiatric hospita	lizations?	Y/N If y	es, when?		
Where?	Reason? _				
Medical History					
Your personal physician:					
Are you on any prescription medication	ons? Y/N	l			
If yes, please list:					
Medication (and dose)	Condition		Prescribing Doctor		
Have you started puberty? Y/N	If yes, ap	pprox. who	en did it start?		
Have you been sexually active? Y/N	If	yes, was l	birth control used? Y/N		
Have you ever used (check any that a Cigarettes Alcohol Marijua		nhalants	Street Drugs		
Are you currently doing any of these?					
<u>Family</u>	/ Social	History			
If you do not live with both parents, when the parents in home?	what is the v	visitation a	arrangement with parent		
Have you ever lived with any other per (include relationship, dates):	erson beside	e parent?	If yes, please explain		
Have you ever been abused physically	,, sexually, o	or emotion	nally? If yes, please explain:		



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

Have you witnessed violence in the home or had a severely traumatic experience? 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:	<u>-</u> —			
How do you get along with your parents?	_			
Thank you for your time.				



Read, sign and accept the policy below:

If parents are divorced or separated, <u>we need to have the appropriate court documents in the teen's records</u> 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