ADOLESCENT INFORMATION FORM

****Completed by Adolescent****

DATE______________________

GENERAL INFORMATION

Name_________________________________ Gender ____ Age____ Birth date_________________
Whom do you live with? ____
Mother: ________________________________ Phone # ____-____-________
Father: ________________________________ Phone # ____-____-________
Whose idea was it for you to come to counseling? ___Parent ___Doctor ___School ___Self ___Other

CURRENT PROBLEM/HISTORY

1. Briefly state what brings you into counseling? ____
____
____

____ Sad/Depressed ____ Self-injury/cutting ____Abuse issues
____ Anxiety/worry ____ Suicidal thoughts ____ Emotional
____ Trouble concentrating ____ Anger management ____ Physical
____ Alcohol/Substance Abuse ____ Trouble with family ____ Sexual
____ Eating problems ____ Low self esteem
____ Ruminating thoughts ____ Uncomfortable around others

2. How long have you been experiencing these problems? ________________________________
____

3. Describe how these problems affect your daily living:

Work:
____ Conflict with supervisor ____ Conflict with coworkers ____ Poor work performance
____ Absent/late ____ Other: ____________________________

School
____ Not completing homework ____ Conflict with teachers ____ Detention/suspended
____ Failing grades ____ Poor attendance ____ Other: ________________

Relationships
____ Conflict with parents ____ Conflict with friends ____ Relationship break up
____ Trouble saying no ____ No friends ____ Other: ________________

Physical Health/Self-Care
____ Always tired ____ Too little sleep ____ Sleeping all the time
____ Loss of appetite ____ Eating too much ____ Always on the go
____ Don't shower ____ Feel sick ____ Other: ________________

Legal
____ Arrested in the past ____Legal charges pending ____ On probation
Please give a description of charges and dates for the above: ______________________________
____
Name of probation officer: ____

4. What are your goals for counseling? ____
____
____

5. How will you know when you have achieved your goal? ____
____
____

6. Have you ever had fears of doing harm to self, others, or of losing control? Yes____ No____
   If yes, please explain: ____
   ____

STRESSORS/TRAUMA

1. Have you experienced any of the following in the last 2 years?

Check if yes	Event
	Move to a new place
	Change of school
	Serious illness or injury in family
	Death of a parent
	Death of a close friend or relative
	Death of a pet
	Parental separation or divorce
	Prolonged separation from parent
	New person in household
	Physical Abuse
	Sexual Abuse
	Emotional Abuse
	Witnessed violence towards family member
	Accident or serious injury
	Change in family's financial status
	Other stressful or traumatic events:

MENTAL HEALTH HISTORY

1. Please list any previous or present counseling experiences and/or hospitalizations:

Date of Service	Agency, Counselor, or Hospital	Problem

2. Have you ever had any out of home placements? Yes____ No____
   If yes, where were you placed and why? ____
   ____

MEDICAL HISTORY

1. Name and address of physician or medical group____

   Date of last appointment: ________________Reason ____

2. Please list other providers you visit (chiropractors, acupuncture, etc.): _____________________________

3. How much do you weigh? _________________ How tall are you? ___________________________

4. Are you taking any prescription medications? Yes____ No_____

   If yes, list ________________________ ___________________________

   ________________________ ___________________________

   ________________________ ___________________________

5. Please list any over-the-counter medications/nutritional supplements you take (e.g., aspirin, sinus tablets, laxatives, vitamins, minerals, herbal remedies, etc.)

Name	Amount	How Often	Last Use

6. Are you sexually active? Yes____ No_____

   If yes, what type of protection do you use? ____

7. Have you ever had: (For any yes responses, please give date/outcome)

	Yes	Date/Outcome
Accidents		
Allergies		
Anorexia		
Arthritis		
Asthma		
Attention Deficit Disorder		
Back pain		
Brain Injury		
Breathing Problems		
Broken Bones		
Bulimia		
Cancer		
Cardiac Problems		
Chest pressure/heaviness		
Chronic Fatigue Syndrome		
Dental Problems		
Diabetes		
Enlarged heart		
Fibromyalgia		
Gastrointestinal Problems		
Headaches		
Heart Murmur		
Hearing Problems		
High Blood Pressure		
High Cholesterol		
Kidney problems		
Liver disease		
Lung disease		
Lupus		
Lyme disease		
Menopause		
Muscle Spasms		
Neurological problems		
Numbness		
Pain in chest		
PMS		
Rheumatic fever		
Seizures		
Surgery		
Thyroid Problems		
Ulcers		
Visual Problems		
Work injury		
Other ________________		

CHEMICAL HEALTH HISTORY

1. Please check current chemical use.

_____ No chemical use   _____ Alcohol   ____ Amphetamines
_____ Marijuana   _____ Speed   ____ LSD/acid/angel dust
_____ Caffeine   _____ Heroin   ____ Cocaine/crack
_____ Sleeping pills   _____ Diet pills   ____ Other: _______________

2. Do you smoke cigarettes? Yes____ No____ If yes, how much and for how long? _______________

3. Do you have a history of chemical use/abuse? Yes____ No_____
   If yes, please explain ____
   ____

4. Have you ever attended chemical dependency treatment? Yes____ No_____
   If yes, please describe program and date of service ______________________________________
   ____

5. Any family history of alcohol/drug use? Yes____ No_____
   If yes, who? ____

	YES	NO
Have you used more than one chemical at the same time in order to get high?		
Do you avoid family activities so that you can use chemicals?		
Do you have a group of friend who use chemicals?		
Do you use to improve your emotions, such as when you feel sad or depressed?		

CURRENT LIVING SITUATION (Regarding the family you live with currently)

1. Please provide your current family information: (include all pregnancies & adoptions)

Name of family member	Relationship	Age	Occupation	Live with me Yes or No
__________________	_____________	_____	_________________	________________
__________________	_____________	_____	_________________	________________
__________________	_____________	_____	_________________	________________
__________________	_____________	_____	_________________	________________
__________________	_____________	_____	_________________	________________
__________________	_____________	_____	_________________	________________

2. Which descriptors characterize your mother or maternal caretaker (check all that apply)?

____ Warm   ____ Distant   ____ Domineering   ____ Abusive
____ Uncaring   ____ Strict   ____ Unpleasant   ____ Rejecting
____ Understanding   ____ Perfect   ____ Affectionate   ____ Over-protective
____ Fault finding   ____ Lenient   ____ Inconsistent   Other: ______________

3. Which descriptors characterize your father or paternal caretaker (check all that apply)?

____ Warm   ____ Distant   ____ Domineering   ____ Abusive
____ Uncaring   ____ Strict   ____ Unpleasant   ____ Rejecting
____ Understanding   ____ Perfect   ____ Affectionate   ____ Over-protective
____ Fault finding   ____ Lenient   ____ Inconsistent   Other: ______________

4. Are your basic needs met (housing, clothing, food, etc.)? Yes_____ No_____
   If no, specify need not being met: ____

5. Do you feel safe in your current neighborhood/community? Yes ____ No _____
   If no, why not? ____

6. Do you have access to firearms at home? Yes ____ No _____
   If yes, are the firearms secured? Yes ____ No _____

EDUCATION HISTORY

1. Which school do you attend? ________________________________ What grade are you in? ______

2. In general, what grades do you achieve in school?
____ Mostly A's ____ Mostly A's/B's ____ Mostly B's/C's ____ Mostly C's ____ Many D's/F's

3. Have you ever repeated a grade? Yes_____ No _____ If so, when: ____________________

4. Do you ever get into trouble in school? ____ Often ____ Occasionally ____ Seldom/Never

5. Do you ever experience bullying in school? Yes _____ No _____

6. Do you participate in any extra-curricular activities, sports, or clubs? Yes_____ No _____
   Please list: ____
   ____

EMPLOYMENT HISTORY

Do you have a job? Yes _____ No _____
   Employer: ____
   Position Title: ____________________________ Length of time at job: ____________________

RELATIONSHIPS/STRENGTHS

1. Please describe your interactions with friends/peers:

______ shy or timid
______ bossy or controlling
______ frequent fights with peers
______ usually a follower
____ have many friends
____ have few friends
____ no friends/loner
____ prefer older friends
____ prefer younger friends
____ usually a leader

2. Are there any other relationships that are important to you? Yes _____ No _____
   If yes, please explain: ____
   ____

3. Please list some of your personal strengths/qualities: ____
____

FAITH/SPIRITUALITY BELIEFS

Please describe your spiritual/faith beliefs and its importance in your life: __________________________
____
____