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(For Parent(s)/Caregiver(s) to Complete)

Client Information – Adolescent

Adolescent's Information

Child's Name _____ Today's Date:_____

Child's Birthdate: _____ Age:_____

Gender: _____ Pronouns: _____ Ethnicity(ies): _____

Address _____ City _____ State ____ Zipcode _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of School: _____ Grade Level: _____

Parent/Guardian Emergency Contact Information

Parent/Guardian Name #1: _____ Birthdate: _____ Age: ____

Address (if different from above): _____

Occupation: _____ Place of Employment: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____
Email address: _____

Parent/Guardian Name #2: _____ Birthdate: _____ Age: ____

Address (if different from above): _____

Occupation: _____ Place of Employment: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____
Email address: _____

Parents are currently: ☐ Married ☐ Divorced ☐ Remarried ☐ Never Married

Child's Siblings and Other People who Live in the Household

Names	Age	Gender	Relationship
~~~~~~

Medical Information

Child's physician: _____ Current medications: _____

Current Health/medical concerns: _____

What Brings You to This Appointment

Referred by: _____

Child's Presenting Problem/Concerns: _____

_____

_____

How do the current concerns impact your family? _____

_____

_____

_____

What are your child's strengths/talents? Family's strengths? _____

_____

_____

_____

Past counseling? (Please indicate name of therapist, dates, type of treatment, and outcome)

_____

_____

Has there been any abuse of this child? ☐Yes ☐ No If yes, please describe: _____

_____

_____

Any legal actions pending or history of legal action? ☐Yes ☐ No If yes, please describe:

_____

_____

School concerns/stresses? _____

_____

_____

Family concerns/stresses? _____

_____

_____

Developmental History

Pregnancy/Delivery: Any prenatal medical illnesses? _____

_____

Any birth complications or problems? Was the child premature? _____
_____

Milestones
At what age did your child?:

_____ Held head up	_____ Crawled	_____ Used sentences
_____ Turned over	_____ Was weaned	_____ Was toilet trained
_____ Sat up	_____ Fed self	_____ Slept through the night
_____Walked alone	_____ Used single words	_____ Dressed self

Please describe your child's temperament/personality during the first few months of life?:
_____

Medical History List all childhood illnesses, hospitalizations, mediations, allergies, head injuries, important accidents and injuries, surgeries, period of loss of consciousness, convulsions/seizures, and other medical conditions:

Condition	Age	Treated by whom?	Consequences?

_____
_____
_____
_____
_____
_____

Family Psychiatric History (Please describe).
_____
_____
_____
_____

Other

Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important? _____
_____

Client/Parent/Guardian Signature _____ Date _____

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Adolescent Information Form (12 years and older)

Note: Unless there is a serious risk of injury to you or someone else, the information on this form is confidential. It will not be discussed with your parents without your consent.

Your name:_____ Today's date: _____ Your age: _____

Your ethnicity(ies): _____ Your gender: _____ Preferred pronoun(s): _____

Your address: _____ Phone #: _____

Your email address: _____

Family

Birth Parents' names: _____ and _____

Address: _____ Phone #: _____

Present Parents'/Guardians' names: _____ and _____

Address: _____ Phone #: _____

How would you describe your parents' relationship? _____
_____

What kinds of problems are you having with?:

Parents/ Stepparents/Guardians? _____
_____

Brothers or sisters (or stepbrother or stepsisters?) _____
_____

School

Which school do you go to? _____ Grade level/year: _____
How are your grades? _____
Problems in school? Please describe._____
_____

Health/Medical History:

How tall are you? _____ How much do you weigh? _____
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What physical or medical problems do you have now, or have you had in the past? _____
_____

Friends

Who are your close friends (names and ages?)_____
Problems with peers/friends? _____
_____

Do you have a serious one-on-one relationship now? _____

What is your sexual preference/orientation? _____

Substance Use

Have you ever used alcohol? __ Y __ N Other drugs? __ Y __ N
If so, what kind? _____ How often? _____

Work

Do you work? _____ If so , where? _____
Problems at work? _____

Previous counseling

1. With whom? _____ When? _____
   For what? _____
   With what results? _____

2. With whom? _____ When? _____
   For what? _____
   With what results? _____

Concerns

Would you like information or answers on:

☐ Sex ☐ Alcohol ☐ Drugs (If so, which? _____) ☐ Birth control ☐ Relationships ☐ Other

1. Have you ever had thoughts of hurting yourself? Please describe.
_____
_____

2. What worries or upsets you?
_____
_____

3. What makes you happy?
_____
_____

4. Is religion important to you and/or your family? If so, in what ways?
_____

_____

5. Why do you think you are here? Please tell me in your own words.

_____

_____

6. What would you like to see happen or change because of this counseling?

_____

_____

7. What would you like me to let your parents know?

_____

_____

8. What else is important for me to know?

_____

_____

9. What would you like me to ask you about?

_____

_____

Signed: _____ Date: _____

Teen Checklist: Have you had any of the following experiences or problems, now or in the past? Please mark below.

Now	Past		Now	Past	
		Restless and unable to sit still			Fearful
		Act without thinking			Worry a lot about the future
		Trouble with paying attention			Unusual fears or phobias
		Low motivation			Panic
		Short attention span			Overly concerned about germs, safety and/or health issues
		Easily frustrated			Repeat an act over and over that is not necessary to do
		Easily distracted			(e.g. washing, checking locks, counting, lining things up)
		Daydream or fantasize a lot			Seem confused a lot
		Temper outbursts			Can't control body movement
		Back talk			Not knowing where you are
		Hard to admit mistakes			Feeling odd or different than other people
		Argue a lot			Blurred or double vision
		Enjoy "bugging" people			Slurred speech
		Swear or use obscene language			Eat little or fast to lose weight
		Easily annoyed by others			Vomit food intentionally
		Use alcohol/drugs			Gorge food
		Smoke cigarettes			Hearing voices or seeing things that aren't there
		Rebellious attitude or behavior			Headache
		Damaged property			Sadness, crying &/or depression
		Want to run away from home			Hard to make decisions
		Stolen things			Irritable/angry
		Have run away from home			Withdrawn from others
		Hurt animals			Trouble concentrating
		Sneak out at night			Trouble going to sleep
		Hurt people			Memory problems
		Sexual problems			Restless sleep, wake up frequently
		Problems with the law			Nothing fun anymore
		Fire setting			Wake up very early and can't go back to sleep
		Been arrested, in jail or on probation			Cutting or injuring myself
		Nervous/can't relax			Sleep too much
		Worry more than others			Feeling tired and fatigued
		Very anxious			Nightmares, night fears
		Worry a lot about past behavior			Weight gain or weight loss
		Low self-esteem			Have made suicide attempts in the past