CONFIDENTIAL CLIENT INFORMATION AND SOCIAL HISTORY
For ADOLESCENTS

To be completed by legal care provider -- custodial parent or legal guardian. Please complete as much of this form as possible. The counselor will use this background information to aid in achieving counseling goals. This form becomes a part of a confidential patient record. While holding the right to review the content of the record as legal guardian/parent, it is recommended that this not be requested for the establishment and maintenance of rapport between your teenager and the counselor. Regular treatment updates will be offered to legal guardians and most often, family sessions will be conducted on a regular basis to include the teen and parents/legal guardians.

Today's Date_____

Client's (Teens) Name_____ ☐M ☐ F Date of Birth_____ Age _____

Address_____City_____State_____Zip_____

Name of Caregiver: _____Emergency Contact name/number: _____

Telephone of caregiver: Home_____Work_____Cell_____

Caregiver's Email Address_____
(Email is used for appointments and administration, but not for counseling. By giving us your email address you are giving us permission to contact you related to appointments and administration. We cannot guarantee the privacy of email.)

Please indicate where we may leave a voice message and send correspondence by mail:

_____

Do you agree to receiving text reminders for appointments? ☐ Yes ☐No

FAMILY INFORMATION
Please complete regardless of living arrangements or death for biological or adoptive parents.

Father's Name _____ Age _____ Education _____

Mother's Name _____ Age _____ Education _____

Father's Occupation _____Length of time with current employer _____

Mother's Occupation_____ Length of time with current employer _____

Hours at work weekly: Mother _____ Father _____ Current Caregiver, if neither Mother or Father _____

Are the mutual parents married? ☐ Yes ☐No, if yes, years married _____

Separated? ☐ Yes ☐No If yes, length of time separated _____

Divorced? ☐ Yes ☐No If yes, length of time divorced _____

Remarried? ☐ Yes ☐No If yes, length of time remarried _____

Father previously married ? ☐ Yes ☐No Father remarried? ☐ Yes ☐No Children from previous marriage or remarriage: _____

Mother previously married? ☐ Yes ☐No Mother remarried? ☐ Yes ☐No Children from previous marriage or remarriage: _____

Siblings of Teen (*if more space is needed please continue on back of page).*

Name	Sex M/F	Age	Custody Status (if applicable)	Describe current relationship with this child and the teen client

Living Environment

List the people who currently live in your home:

Name	Age	Relation	Describe the current condition of your relationship with this person

EDUCATION

Current School and Grade: _____

Academic performance? _____

Extracurricular Activities _____

_____

Disciplinary problems at school: _____

PRESENTING PROBLEM

Please tell me about the primary problems/complaints which bring your teen to counseling; please use the adjacent lines to explain:

- ☐ Mood _____
- ☐ Relationship _____
- ☐ Recent loss/major change _____
- ☐ Occupational _____
- ☐ Spiritual _____
- ☐ Sleep _____
- ☐ Appetite _____
- ☐ Energy _____
- ☐ Concentration _____
- ☐ Addictive behavior: ☐ pornography ☐ sex ☐ alcohol ☐ drugs ☐ gambling ☐ other _____
- ☐ Troubling memories of the past _____
- ☐ Low self-worth _____
- ☐ Thoughts of harming self _____
- ☐ Thoughts of harming others _____

What do you hope is the outcome of counseling? _____

_____

_____

_____

MEDICAL

Please list any past or current significant medical diagnosis or illness:

_____

_____

Please list all medications recently (LAST 6 MO)/currently taken including over the counter:

Please list any previous OR current counseling providers, diagnoses and dates:

Any use of ☐alcohol ☐ tobacco ☐marijuana ☐other _____

☐other's prescription medications_____

Has your child ever been hospitalized for psychiatric reasons; if so, please provide the dates and place

LEGAL

Please list any past or current legal problems:

SIGNIFICANT EVENTS

Has your child ever experienced ☐ physical abuse ☐ sexual abuse ☐ emotional abuse?

Has your child ever been exposed to other traumatic events such as ☐ natural disaster ☐violence ☐other (please explain): _____

Do any of the above experiences continue to cause them problems? ☐yes ☐no

INTERESTS AND STRENGTHS

Please tell me about your teens interests, activities, hobbies: _____

Please list at least three strengths/likes about your teen: _____

SPIRITUAL BELIEFS/ACTIVITIES

Please briefly tell me about you and your teens current beliefs and practices: _____

Duration of your teens beliefs/practices_____

Do you and/or your teen have interest in applying Christian Biblical truths and prayer in counseling? ☐yes ☐no

Explain: _____

The above information is true to the best of my knowledge _____

Signature of Parent/Legal Guardian