Sabine Boots, M.S., LMFT
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Teen Information

Name : ________________________ Date of Birth: _______ School Grade: ____

Siblings: __________________________ DOB: _________ School Grade: ____

__________________________ DOB: _________ School Grade: ____

Name of Parent: _________________________ DOB: ________

Profession: _____________________________

Spouse/Partner: ___________________________ DOB: ________

Profession: _____________________________

Mailing address:

____

Phone number home: ______________________ Cell: ________________________________

E-mail address: ____

Is it OK to contact you via e-mail? Please initial: Yes ______, No ______

(due to the nature of the Internet safeguarding of information cannot be guaranteed by the therapist)

Referring source (physician/other): ____

Have you ever:

Seen a psychologist ____, counselor ____, psychiatrist ____, or been admitted to a psychiatric hospital?

If so, when and for what concerns?

____

Are you currently taking any medications? If yes, which:

____

Have you ever developed any health problems that required a hospital stay?

____

What are your sleep patterns?

Regular ____ interrupted sleep ____ difficulties going to sleep____

sleep walking ____ Asleep during the day ____ nightmares/terrors ____difficult to wake up ___

On average, I sleep ____ hours per night

What are you most concerned about in your life right now?

____

____

____

Is there a history of depression and or suicide in your family? If yes, please explain:

____

Have you ever thought about or attempted suicide?

____

Do you want to loose, maintain, or gain weight?

____

Do you have a history of dieting?

____

Please, answer following questions using the numbers 1-5:
1=never, 2=rarely, 3=sometimes, 4=frequently, 5=almost always

1. I feel stressed at school. _____
2. It's easy for me to make friends. _____
3. I have difficulties with concentration. _____
4. I have disturbing thoughts in my mind. _____
5. I have bowel problems, such as constipation, diarrhea, and/or stomach cramps. ______
6. I experience headaches. ______
7. I feel depressed. _____
8. I have problems with my self-esteem. ______
9. I am worried about my family. ______
10. I have problems with my eating behavior. _______

Anything else you'd like me to know?

____

____

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