LUCY T. SMITH, PHD

CLINICAL PSYCHOLOGIST

Adolescent Information Form

Date: _____

Adolescent Information:

Name: _____ Age: _____ DOB: _____

Address: _____

Street Apt City State Zip

Phone: Home _____ Is it okay to leave a message? No Yes

Cell _____ Is it okay to leave a message? No Yes

Employment (if any): _____

Mother's Information:

Name: _____ Age: _____

Address: _____

(if different) Street Apt City State Zip

Phone: Home _____ Is it okay to leave a message? No Yes

Cell _____ Is it okay to leave a message? No Yes

Work _____ Is it okay to leave a message? No Yes

E-mail: _____

Highest Grade/Degree: _____ Employment: _____

Father's Information:

Name: _____ Age: _____

Address: _____

(if different) Street Apt City State Zip

Phone: Home _____ Is it okay to leave a message? No Yes

Cell _____ Is it okay to leave a message? No Yes

Work _____ Is it okay to leave a message? No Yes

E-mail: _____

Highest Grade/Degree: _____ Employment: _____

Parents' Marital and Custody Status:

Marital Relationship: married separated divorced never married

If divorced, please describe custody arrangements: _____

_____

Sibling Information:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Others living in your home? _____

Other Information:

School: _____ Grade: _____

Pediatrician: _____ Phone: _____

Other professional: _____ Phone: _____

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Prior Mental Health Treatment:

Has the client ever been hospitalized for a psychological or psychiatric issue? YES NO

If yes, please describe:

Has the client ever received treatment for mental health or substance use concerns? YES NO

If yes, please provide dates, type of treatment, provider information, duration, and helpfulness below.

Any history of suicidal thoughts or attempts? YES NO

If yes, when?

Medical History:

When was the client's most recent physical exam? _____ Allergies: _____

Please list all current medications: _____

Significant medical concerns or conditions:

_____

History of head injury, seizures, or loss of consciousness?

_____

Legal History:

Has the client ever been arrested or convicted of a legal violation? YES NO

If yes, please describe:

Referral Source:

Referred to Dr. Lucy Smith by: _____

May I contact your referral source to acknowledge the referral? YES NO

Reason for Visit:

What are the main reasons you are seeking treatment? Please check all that apply.

□ Sadness/Depression
□ Anxiety/Worry
□ Fear
□ Stress
□ Physical Symptoms
□ Grief/loss
□ School Difficulties
□ Social/Family Conflict
□ Other: _____

□ Hopelessness
□ Irritability
□ Anger
□ Low Self-Esteem
□ Sleep Difficulties
□ Suicidal Thoughts
□ Self-Harm
□ Thoughts of Harming Others

□ Perfectionism
□ Eating/Weight Concerns
□ Overexercise
□ Body Dissatisfaction
□ Obsessions/Compulsions
□ Panic attacks
□ Loneliness/Isolation
□ Impulsiveness

By signing below, I give permission for the minor named above to participate in evaluation and/or treatment with Lucy Smith, PhD. I certify that as the minor's custodial parent or legal guardian, I have the legal right to give such permission.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Minor