Melissa Shane Counseling Services LLC

Teen Information Form

Note: Unless there is a serious risk of injury to you or someone else, what you say on this form is confidential between us. I will not discuss it with your parents or anyone else without your consent.

A. Identification

Your name:                           Today’s date:   /  /   Your age:

What name do you prefer to be called?            Gender preference:    Pronoun preference:

B. Health

How tall are you?      How much do you weigh?      What do you think is your ideal weight?

What kind of exercise do you do?                         How often?

Which of these have you used in the last year?  Tobacco  Alcohol  Marijuana   
 Ritalin/other stimulants  Steroids  Hormones  Emetics (to vomit)  Laxatives   
 Other chemicals:

C. Family

Main female caregiver:                  Main male caregiver:

Are these your  birth parents?  adoptive parents?  stepparents?  Other?

How would you describe their relationship?

Do your caregivers have legal issues?

What kinds of problems are you having with:

Your parents/stepparents/guardians/partners of parents?

Your brothers or sisters (or stepbrothers or stepsisters)?

Other members of your family?

What are your responsibilities at home?

How do your caregivers discipline or punish you?

How important is religion/spirituality to your family?  Highly  Not too much  Not important

How important is religion/spirituality to you?  Highly  Not too much  Not important

D. School

Which school do you go to?                      Grade level/year:

Which subjects are hardest for you?

Are you having problems in school? If so, describe:

What are your plans after you graduate?

E. Work

Do you work?  No  Yes. If yes, how many hours a week?

What do you do?                      Where?

Are you having problems at work? If so, describe:

F. Special skills or talents

What are your hobbies?

What sports do you play?

What do you enjoy doing most?

What are your greatest accomplishments and strengths?

G. Your friends and social activities

|  |  |  |  |
| --- | --- | --- | --- |
| Names of best friends | Age | Gender | What do you do together? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Do you party?  Never  Some  Often. If so, when and where?

Do you have a cellphone?  No  Yes. Is it a smartphone?  No  Yes

How many hours a day do you spend online?    Watching TV?    Listening to music?    What kinds of music do you like best?

Circle any of these you use: texting, email, Facebook, Instagram, Twitter, other (specify):

H. Concerns

Would you like information or answers in any of these areas:  Sex  Body changes  Birth control   
 Alcohol  Drugs (if so, which?):

 Adult relationships  Love  Training and jobs  Other:

What worries or upsets you?

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

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

What would you like me to let your parents know?

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

Your signature: