1919 S. 40th St., Lincoln, NE 68506 // (402) 540-1693

ADOLESCENT HISTORY FORM

(To be completed by parent)

Purpose:
The purpose of this questionnaire is to obtain a comprehensive view of your background to save both you and your counselor time. Please be complete and accurate.

This material is personal and will be kept confidential. No one else is permitted to see this record without your written permission. If you do not desire to answer any question, simply write: "Do not care to answer."

I. Client Name_____ Date of Birth _____

Home Address _____

Home Phone ( ) _____ Cell Phone ( ) _____

Age _____ Gender M____ F____

Family

Marital Status of Parents (Circle one) Married Single Divorced Separated Widowed

Family Members (Include names and ages)

Father _____ Birth date____/____/____ Age _____

Mother _____ Birth date____/____/____ Age_____

Step Parent _____ Birth date____/____/____ Age _____

Siblings (list oldest to youngest)

_____ Birth date____/____/____ Age____ Gender: M/F

_____ Birth date____/____/____ Age____ Gender: M/F

_____ Birth date____/____/____ Age____ Gender: M/F

_____ Birth date____/____/____ Age____ Gender: M/F

_____ Birth date____/____/____ Age____ Gender: M/F

If Guardian_____

1. What concerns you most about this adolescent currently? _____

_____

II. Relevant History

A. Counseling

1. Has your adolescent had previous counseling? YES NO

If yes, with whom? _____

For how long? _____

Did it help? _____

2. What goals do you want this counseling to achieve?

_____

_____

_____

3. What specific changes in behavior will indicate to you these goals have been achieved?

_____

_____

_____

4. In your opinion, how likely is it that these goals can be accomplished? (Circle one)

0% 20% 40% 50% 60% 80% 100%

5. How long do you expect counseling to take?

_____

_____

6. In addition to counseling for your child, do you also want help for yourself or your marriage? YES NO

If yes, please explain briefly. _____

_____

_____

B. Psychiatric History

1. Has anyone in your extended family suffered anything that might be considered a "mental disorder" or any other illness that might be relevant?

_____

_____

2. Is there any history of suicidal or homicidal ideation? _____

C. Medical History

1. Date of last physical exam: ____/____/____

2. Name and address of doctor: _____

3. Is your adolescent taking medication now? YES NO

If yes, what?_____ Dosage?_____

For how long? _____

4. Has your adolescent been on any medication within the last 6 months? YES NO

If yes, what?_____ Dosage?_____

For how long? _____

5. Does the adolescent have any medical allergies or reaction? YES NO

If so, what

6. Has your adolescent ever been hospitalized? YES NO

If so, for what? _____

7. Has your adolescent ever had an operation? YES NO

If so, for what? _____

9. Does your adolescent have any neurological or physical handicaps handicaps? YES NO

If so, please specify: _____

10. Where they're any unusual illnesses as an infant? YES NO

If so, please specify: _____

11. Do you believe your adolescent has a medical problem that is not now being treated? YES NO

If so, what? _____

12. Has he or she had any motor coordination, visual, speech, learning or language problems? YES NO

If so, please describe: _____

_____

13. What is your adolescent's sleeping pattern like? (Please circle)

sleeps through the night awakens from sleep appears to be awake but not awake

nightmares sleepwalks wets the bed has difficulty falling asleep

14. Has your adolescent had any of the following? If so, when.

	Yes	Date
Measles	____	_____
Mumps	____	_____
Chicken Pox	____	_____
Whooping Cough	____	_____
German Measles	____	_____
Bronchitis	____	_____
Rheumatic Fever	____	_____

Tuberculosis	____	_____
Pneumonia	____	_____
Diabetes	____	_____
Seizures	____	_____
Broken Bones	____	_____
Tonsillitis	____	_____
Head Injuries	____	_____
Other Serious Illness	____	_____

D. Current Family Life

1. What things are done together as a family in your home?

_____
_____

2. How often does your adolescent participate in these activities?

_____

3. In your opinion, what family activity is most valued by your adolescent?

_____

4. If your family had a motto, what would it be?

_____

5. Has anyone other than parents and children lived in your home for an extended period of time?

If yes, describe who and when. _____

_____

6. Is there any alcoholism or substance use disorder in your family? YES NO

If yes, describe who and when. _____

7. Which below best characterizes your adolescent's overall current home environment?

_____ Unconditional love and acceptance; close relationships

_____ Quiet and peaceful, but relationships are distant

_____ Instability, periods of peace mixed with periods of fighting

_____ Family fighting the norm

_____ Other: _____

8. How would you describe the happiness of the adolescent's parents' marriage?

_____ Very much in love; best of friends; happy

_____ Committed to one another, but not particularly close

_____ Unhappy, but trying to make the best of it

_____ Unhappy, avoid one another as much as possible, fights kept secret from children most of the time

_____ Unhappy, much fighting together, often in front of the children

_____ Separated or divorced, congenial

_____ Separated or divorced, antagonistic, but keep the children out of it

_____ Separated or divorced, and openly antagonistic, on-going conflicts

9. Does your adolescent have a nickname? _____

10. Does your adolescent have any present hobbies, interests, or uses of free time?

_____

_____

11. Does your adolescent have a special meaning to one or more of his/her parents? YES NO

Please specify: _____

12. Who has the strongest influence in your family? _____

13. Does your adolescent identify more with father or mother? _____

14. How is this expressed? _____

15. In solving family conflicts, different styles are used.

Circle the style that best describes family members currently living in your home.

Father:	Win	Compromise	Yield	Withdraw	Resolve
Mother:	Win	Compromise	Yield	Withdraw	Resolve
Adolescent:	Win	Compromise	Yield	Withdraw	Resolve

16. In what ways do you discipline your adolescent?

_____

_____

17. Is your adolescent able to confide in you? YES NO

18. What subjects are difficult for your adolescent to discuss with you?

_____

19. What subjects are difficult for you to discuss with your adolescent?

_____

20. Circle what best describes the parents' style of discipline.

Mother:	Strict	Firm and Loving	Lenient	No limits

Explain: _____

Father:	Strict	Firm and Loving	Lenient	No limits

Explain: _____

21. If the adolescent was/is not being brought up by the parents, who did/is doing the parenting?

_____

22. How old was the adolescent when this occurred?_____

23. Do you have a religious preference? YES NO

If yes, what? _____

24. Does your family participate in a church, synagogue, mosque or other religious group? YES NO

If yes, please specify: _____
_____

25. How regular is your family's participation? _____

26. Does your adolescent also participate regularly? YES NO

If so, in what ways? _____
_____

27. How open are you to the counselor addressing spiritual issues with your adolescent?

_____

28. Has the family moved? YES NO

If yes, when and where: _____

_____

29. Have there been any deaths in the family? YES NO

If yes, please specify: _____

_____

III. Developmental History

A. Prenatal

1. Was the mother's physical health good during the pregnancy? YES NO

2. Was the mother on any medication during the pregnancy? YES NO

If yes, what: _____

3. Was the mother taking drugs or alcohol during pregnancy? YES NO

4. Were there any severe emotional stresses during this pregnancy? YES NO

If yes, please specify: _____

_____

5. Was there any major physical or emotional illness of either parents or grandparents? YES NO

If yes, what: _____

6. Was the pregnancy planned? YES NO

7. Did the mother look forward to this adolescent's birth? YES NO

8. Did the father look forward to this adolescent's birth? YES NO

B. Birth and Infancy:

1. Was your baby's delivery normal? YES NO

If not, please specify: _____

2. Was the pregnancy full term? YES NO

If not, how long? _____

3. Did the mother experience the "blues" after birth? YES NO

4. Was the baby difficult to care for? YES NO

5. If the father was in the home at the time, did he participate in caring for the baby? YES NO

6. Did your adolescent like to be held as an infant? YES NO

7. As a baby, was your adolescent unusually active? YES NO

8. As a baby, did your adolescent sleep more than usual? YES NO

9. As a baby, did your adolescent sleep less than usual? YES NO

10. Would you describe your adolescent's development as normal? YES NO

C. Childhood Years

1. Is your adolescent's social behavior appropriate for his/her age? YES NO

2. Does your adolescent seek out adolescents of the same age with whom to associate? YES NO

3. Is your adolescent able to appropriately "hold his/her own" in group situations? YES NO

4. Does your adolescent have a close friend? YES NO

5. Does your adolescent relate comfortably with members of his/her own gender? YES NO

6. Have you had any indications that your adolescent may have been sexually molested? YES NO

7. Have you ever had any indications that your adolescent may have been physically abused? YES NO

8. Has your adolescent been sexually active? YES NO

9. Has your adolescent been involved in taking any drugs or alcohol? YES NO

10. Does your adolescent have any fears? YES NO

If yes, what? _____

How do you handle it? _____

11. Do you have any difficulty getting your adolescent to talk to you? YES NO

12. Does your adolescent have any angry outbursts or temper tantrums? YES NO

If yes, how often? _____

Are there any common issues? _____

What does he/she do? _____

How do you handle it? _____

13. Does your adolescent have crying spells? YES NO

If yes, describe: _____

_____

14. Are there ways in which your adolescent gives you pleasure? YES NO

If yes, describe: _____

_____

15. What are your adolescent's strengths?

_____

_____

_____

_____

D. School History

1. School adolescent attends: _____

Grade: _____

2. Does your adolescent enjoy school: YES NO

3. Does your adolescent generally complete his/her homework assignments on time? YES NO

4. Is studying a problem for your adolescent? YES NO

5. Is your adolescent in a special class? YES NO

If yes, what class: _____

6. Is your adolescent having behavioral problems at school? YES NO

7. Is your adolescent achieving at expected level? YES NO

8. Please circle the word that best describes your adolescent's grades.

Superior Above Average Average Below Average Failing

9. Has your adolescent missed much school? YES NO

10. Has your adolescent had a recent marked change in academic performance? YES NO

11. Does your adolescent belong to any social or athletic group? YES NO

If yes, please specify: _____

_____

12. What educational ambitions or goals does your adolescent have?

_____

13. Has your adolescent ever been in trouble with the law? YES NO

If so, please specify: _____

Person completing questionnaire: _____
Relationship to Adolescent: _____
Date: _____