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Psychotherapist

ADOLESCENT CLIENT INFORMATION

Name _____ **Date** _____

Address _____ Age _____
City, State, Zip _____ Sex _____ M _____ F
Home Phone _____ DOB _____
Cell Phone _____
Email _____
School _____ Grade _____
Current Job _____
Employer _____

Please describe the reason for your visit: _____

How serious is this issue for you (on a scale of 1-10: 1=not serious, 10 =most serious)? _____

How does this issue affect your ability to function (go to school or work, do homework, be with friends or family, deal with your feelings)? _____

How long have you been experiencing upset about this issue? _____

Background Information

Parents/Guardians/Step-Parents:

Name	Age	Job / Retired	Physical/Emotional/Psychological Problems

Siblings (Brothers and Sisters):

Name	Age	Job / Retired	Physical/Emotional/Psychological Problems

Children:

Name	Age	Grade	Physical/Emotional/Psychological Problems

Current living situation: Apartment [ ] House [ ] Multiple Homes [ ] Other [ ]
Others living with you: Mom [ ] Dad [ ] Step-parent [ ] Children [ ] Grandparent [ ] Other [ ]
If Multiple Homes, Time Spent at Each Home _____

Check the problems that trouble you **in your family:**

___ Family member physically sick
___ Family member has emotional problems
___ Family member struggles with alcohol/drugs
___ Parents never home
___ Can't talk to mom or dad
___ Parent/guardian too strict
___ Don't feel close to family
___ Parent/guardian expects too much
___ Parent/guardian disapproves of friends
___ Parent/guardian disapproves of clothes, appearance
___ Parent/guardian disapproves of activities, music
___ Parent/guardian favors brothers or sisters
___ Parent/guardian ignores me
___ Parents fighting
___ Parents divorcing
___ Problems with stepparent
___ Being emotionally or physically abused at home
___ Being sexually abused at home
___ Don't want to live at home
___ Don't have enough privacy
___ Pet dying
___ Fighting with brother/sister
___ Other: _____
_____

Check the problems you are experiencing in yourself:

____ Depressed Mood
____ Suicidal thoughts/attempts
____ Reduced or low motivation
____ Attitude issues
____ Bored
____ Confused
____ Difficulty being alone
____ Tired
____ Cutting self (or hurting self in another way)
____ Feelings of guilt, shame or badness
____ Hearing voices/hallucinations
____ Mood swings
____ Easily irritated
____ Memory/concentration problems
____ Distractible
____ Disorganized
____ Focusing problems
____ Hyperactivity
____ Impulsive
____ Lonely
____ Anxious, worried
____ Obsessive thoughts
____ Panic attacks
____ Rigid routines
____ Organize excessively
____ Trouble shutting mind off
____ Unusual thoughts/unwanted thoughts
____ Anger problems/aggressiveness
____ Shy/uneasy with others, unassertive
____ Self-esteem low
____ Sexual problems
____ Sexual identity concerns
____ Sleep problems: ___ At times it takes me over ½ hour to get to sleep. ___ wake up a lot at night.
____ Eating habits
____ Restricting ____ Bingeing ____ Purging (making yourself throw up)
____ Laxative use for dieting ____ Overeating ____ Over-exercising
____ Body image issues
____ Drug/alcohol abuse
____ Legal problems
____ Perfectionist
____ Lying frequently
____ Sick a lot
____ Withdrawn
____ Tearful
____ School issues
____ Job issues
____ Friendship issues
____ Relationship issues
____ Living arrangement problems
____ Money management problems
____ Weight changes [ ] increase [ ] decrease
____ People put me down
____ I don't have enough friends
____ I'm excluded
____ I don't like my appearance
____ My grades worry me
____ I don't like myself
____ I don't like the way I treat people
____ I feel I don't fit in with my peers
____ I have trouble saying "No"
____ I feel inferior
____ I like to argue/compete with others
____ Have trouble living up to other's expectations.
____ People's opinion of me is very important
____ I get in fights a lot.
____ I try to get my own way a lot.
____ I try to please everyone.
____ I think I'm right all the time.

Medical/Physical History:
Medical concerns in the last year: _____
Chronic illnesses/Disabilities: _____
Surgeries: _____
Average hours per night of sleep: _____
Usual sleep routine (including when you fall asleep and wake up; weeknights vs. weekends): _____
_____
_____
Current medications/Dosages/Reasons prescribed: _____
_____

Counseling/Therapy:
Dates Clinic/Therapist Reason
_____
_____
_____

Psychiatric Hospitalizations: (Dates/Hospital/Reason)
_____

Abuse Issues:
Please indicate (ü) areas of **abuse that you have encountered**: (¨ Not applicable)

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

Please indicate (ü) areas of **abuse by you**: (¨ Not applicable)

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

Alcohol / Drug Use:
Chemical Use:

Past and Current Use	Type	Quantity	Frequency	When Started – When Ended if applicable
Alcohol				
Tobacco				
Illicit Drugs				

In the last year, what alcohol and/or mood-altering drug have you used? (Include how much & how often): _____

_____

What is the most number of drinks you have had on any given day in the past year? _____

Have there been any undesirable results of your chemical use? (low job or school performance, physical problems, relationship problems, DWI's) [ ] Yes [ ] No
Have you ever been concerned about your own chemical use? [ ] Yes [ ] No
Have others expressed concern about your chemical use? [ ] Yes [ ] No
Have others who are close to you abused alcohol or drugs? [ ] Yes [ ] No
If yes, who? (include family, friends) _____

Have you ever attended treatment for your chemical use? [ ] Yes [ ] No
Have you ever attended a support group (ie: AA, NA, Al-Anon)? [ ] Yes [ ] No
Are you currently attending a self-help or support group? [ ] Yes [ ] No
Name of group _____

Describe your daily caffeine consumption (include coffee, tea, pop, chocolate):

_____

_____

Social History:
How many close friends do you have at this time? _____
Approximately how often do you have contact with these friends? _____
How do you connect with these friends? _____
Approximately how much time per day do you spend on electronics/social media/internet (please describe time spent doing what specifically)? _____

_____
What type of exercise do you participate in and how often? _____

_____
What are your interests and hobbies? _____

_____

Educational Issues:
Trouble with: grades _____ absences _____ skipping ____ teacher relationships _____
Learning problems/disabilities _____
Other problems with school _____

Job Issues:
List your last three (3) jobs: _____
What issues have you had at your job? _____
What are your strengths at your job? _____

Religion/Spirituality:
List religious affiliation/spiritual involvements/preferences _____
Is religion/spirituality important to you? _____

Culture:
Ethnic background (ie: Hmong, African American, German, Irish, etc.): _____

_____
List any important customs and beliefs of your culture that are important to you: _____

_____

Client Expectations

What do you hope to get help with in therapy? _____

What do you hope to gain from therapy? _____

How do you think you will know when you have reached your therapy goals? _____

How long do you expect to participate in therapy? _____