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Adolescent/Child Demographic Information and History (to be completed with parent/guardian)

Date of Initial Contact _____**Date of Initial Session**_____

Client Name: _____**DOB:**_____

Address: _____

_____

_____**OK to send mail to address?**_____

Telephone Contact Numbers

Home:	Leave Message?
Cell:	Leave Message?
Email:	

Emergency Contact Numbers:

Relative:_____

Relative:_____

Friend: _____

Professional (MD, Therapist, etc.)_____

Other: _____

Referred by: _____

School

Grade:_____

School Name: _____

Address:_____

Guidance Counselor_____

Telephone Number:_____Contact?_____

Attorney/Guardian ad Litem: Name, address and phone:_____

_____

Briefly describe your reason for beginning counseling/therapy NOW.

_____

_____

_____

_____

_____

Name:_____

At this time, what would you like to change (i.e., goals for counseling/therapy)?

_____

_____

_____

_____

_____

Living situation:
❑ Housing adequate
❑ Homeless
❑ Housing overcrowded
❑ Dependent on others for housing
❑ Housing dangerous/deteriorating
❑ Living companions dysfunctional

Social support system:
❑ Supportive network
❑ Few friends
❑ Substance-use-based friends
❑ No friends
❑ Distant from family of origin

Academic:
❑ In school and satisfied
❑ In school but dissatisfied
❑ Not in school
❑ Peer conflicts
❑ Teacher conflicts
❑ Unstable academic history
❑ Disabled:_____

Financial Situation
❑ No current financial problems
❑ Large indebtedness
❑ Poverty or below-poverty income
❑ Impulsive spending
❑ Relationship conflicts over finances

Legal history:
❑ No legal problems
❑ Now on parole/probation
❑ Arrest(s) not substance related
❑ Arrest(s) substance related
❒ Ever seriously hurt or killed anyone?_____ Ever any desire to seriously hurt or kill someone?_____
❑ This treatment court ordered
❑ Juvenile Detention _____time(s) Total amount of time in juvenile detention:_____
❑ Describe last legal difficulty _____

Current Symptom Checklist

None=This symptom is not present at this time; Mild=Impacts quality of life, but no significant impairment of day-to-day functioning; Moderate=Significant impact on quality of life and/or day-to-day functioning; Severe=Profound impact on quality of life and/or day-to-day functioning:

Symptom	None	Mild	Moderate	Severe
Depressed Mood				
Appetite Disturbance				
Sleep Disturbance				
Elimination Disturbance				
Fatigue/Low Energy				
Psychomotor Retardation				
Poor Concentration				
Poor Grooming				
Mood Swings				
Agitation				

Symptom	None	Mild	Moderate	Severe
Emotionality				
Irritability				
Generalized Anxiety				
Panic Attacks				
Phobias				
Obsessions/Compulsions				
Binging/Purging				
Laxative/Diuretic Abuse				
Anorexia				
Paranoid Ideation				
Circumstantial Symptoms				
Loose Associations				
Delusions				
Hallucinations				
Aggressive Behaviors				
Conduct Problems				
Oppositional Behavior				
Sexual Dysfunction				
Grief				
Hopelessness				
Social Isolation				
Worthlessness				
Guilt				
Elevated Mood				
Hyperactivity				
Dissociative States				
Somatic Complaints				
Self-Mutilation				
Significant Weight Gain/Loss				
Concomitant Medical Condition				
Emotional Trauma Victim/Survivor				
Physical Trauma Victim/Survivor				
Sexual Trauma Victim/Survivor				

Symptom	None	Mild	Moderate	Severe
Emotional Trauma Perpetrator				
Physical Trauma Perpetrator				
Sexual Trauma Perpetrator				
Substance Abuse				
Other (Specify)				

Describe the development of the issue that led you to enter counseling/therapy?

_____

_____

_____

_____

_____

How has the issue affected other major life areas? (For example, who has complained, has it interfered with family relationships, social relationships, school, spirituality, led to legal problems or affected your physical health?)

_____

_____

_____

_____

What are your strengths?

_____

_____

_____

What skills do you have?

_____

_____

_____

Cultural/spiritual/recreational history:

Cultural identity (e.g., ethnicity, religion)_____

Describe any cultural issues that contribute to current problem_____

_____

Currently active in community/recreational activities? ❑ Yes ❑ No

Formerly active in community/recreational activities? ❑ Yes ❑ No

Currently engaged in hobbies? ❑ Yes ❑ No

Currently participate in spiritual activities? ❑ Yes ❑No

Name:_____

Name:_____

What do you like to do in your spare time?

_____

_____

_____

_____

_____

Support System (Who supports or helps you? How?)

_____

_____

_____

_____

_____

What values and beliefs are important to you?

_____

_____

_____

_____

_____

Medical History:

Describe current physical health: ❑ **Good** ❑ **Fair** ❑ **Poor**

_____

_____

_____

List name of primary care physician (include address and phone number)

_____

_____

_____

List name of psychiatrist (if any) (include address and phone number)

_____

_____

List any known allergies:

_____

_____

List all current medication and dosage (Include over-the-counter medications & vitamins):

_____

_____

_____

List all previous medication and dosage not listed above: _____

_____

Name:_____

Summary of Prior Psychotherapy:
(Inpatient and Outpatient; Psychiatric, Emotional and/or substance use disorder; Include provider name, title; Dates, duration & frequency of therapy; Reason for seeking treatment; What kind of therapy; Was it helpful; and Did you have any negative reactions?)

_____
_____
_____
_____
_____
_____
_____
_____
_____

Any family member have outpatient therapy?

_____
_____
_____

Has any family member used medications for emotional/psychological issues? If yes, list:

_____
_____
_____
_____
_____
_____
_____

Describe any serious hospitalizations or accidents (include date, age, reason):

_____
_____
_____
_____

List any abnormal lab test results (include date and age)

_____
_____
_____
_____
_____

Name:_____

Medical History of Family:

Is there a history of any of the following for you or your immediate family members (initial: S=Self, M=Mother, F=Father, SP=Step Parent, SB=Sister or Brother, GP=Grandparent, O=Other):

❑ Tuberculosis
❑ High Blood Pressure
❑ Birth Defects
❑ Behavior Problems
❑ Thyroid Problems
❑ Cancer
❑ Mental Retardation
❑ Heart Disease
❑ Emotional Problems
❑ Alcoholism
❑ Drug Abuse
❑ Diabetes
❑ Alzheimer's Disease/Dementia
❑ Stroke
❑ Other_____

SUBSTANCE USE HISTORY

Substance use status:

❑ No history of abuse
❑ Active abuse
❑ Early Full Remission
❑ Early Partial Remission
❑ Sustained Full Remission
❑ Sustained Partial Remission

Treatment History

❑ Outpatient (age/s)_____
❑ Inpatient (age/s)_____
❑ 12 Step Programs (age/s)_____
❑ Stopped on own (age/s)_____
❑ Other (age/s)_____

Consequences of Substance Abuse (Check all that apply):

❑ Hangovers ❑ Binges ❑ Sleep Disturbance ❑ Withdrawal Symptoms
❑ Medical Conditions ❑ Seizures ❑ Assaults ❑ Job Loss
❑ Tolerance Changes ❑ Blackouts ❑ Suicidal Impulse ❑ Arrests
❑ Relationship Conflict ❑ Overdose ❑ Loss of Control of Amount Used
❑ Other_____

Check Substance(s) used and complete all that apply in chart

	First Use Age	Last Use Age	Current Use Yes/No	Frequency	Amount
❑ Alcohol					
❑ Amphetamine/speed					
❑ Barbiturates/downers					
❑ Caffeine					
❑ Cocaine					
❑ Crack Cocaine					

❑ Ectasy					
❑ Hallucinogens (e.g., LSD)					
❑ Inhalants (e.g., glue, gas)					
❑ Marijuana or hashish					
❑ Methamphetamine					
❑ Nicotine/cigarettes					
❑ PCP					
❑ Prescription _____					
❑ Prescription _____					
❑ Prescription _____					
❑ Prescription _____					
❑ Other _____					
❑ Other _____					

Sexual History:

❑ Heterosexual orientation
❑ Homosexual orientation
❑ Bisexual orientation
❑ Currently sexually active
❑ History of unsafe sex age____to____
❑ Additional information_____
❑ Currently sexually dissatisfied
❑ Age first sex experience _____
❑ Age first pregnancy/fatherhood _____
❑ History of promiscuity age____to____
❑Currently sexually satisfied

Any other sexual experiences, problems or concerns?

Name:_____

Name:_____

FAMILY:

List all persons currently living with you (include name, age, sex and relationship to you)

_____

_____

_____

_____

_____

_____

_____

List any biological parents, brothers and sisters <u>not</u> living in the same household as you (include name, age, sex and relationship to you)

_____

_____

_____

_____

Frequency of visitation of above:_____

	Present During Childhood	Present Part of Childhood	Not Present At All
Mother			
Father			
Stepmother			
Stepfather			
Brother(s)			
Sister(s)			
Other (specify)			

Biological Father

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Biological Mother

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Name:_____

Other Primary Care-Giver (e.g., step-parents, nanny, etc.)

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Other Primary Care-Giver (e.g., step-parents, nanny, etc.)

Full Name:_____

Occupation:_____

Education:_____

General Health:_____

Briefly describe your relationship with your biological father. Do you feel close to him?

_____

_____

_____

Briefly describe your relationship with your biological mother. Do you feel close to her?

_____

_____

_____

Briefly describe your relationship with your other primary care givers. Do you feel close to them?

_____

_____

_____

Briefly describe your relationship with your brothers and sisters. Do you feel close to them?

_____

_____

_____

Parents current marital status:
- ❑ Married to each other
- ❑ Separated for _____years
- ❑ Divorced for _____years
- ❑ Mother remarried _____times
- ❑ Father remarried _____times
- ❑ Mother involved with someone
- ❑ Father involved with someone
- ❑ Mother deceased _____ years
  Your age at mother's death ____
- ❑ Father deceased _____years

Your age at father's death_____

Describe your family experience:
- ❑ Outstanding home environment
- ❑ Normal home environment
- ❑ Chaotic home environment
- ❑ Witnessed physical/verbal/sexual abuse toward

  _____

  _____

- ❑ Experienced physical/verbal/sexual abuse from

  _____

  _____

_____

Age of emancipation from home:_____Circumstances:_____

_____

Name:_____

YOUR DEVELOPMENTAL HISTORY:

During your infancy did you experience:

❑ Feeding problems ❑ Sleep problems ❑ Toilet Training Problems

Your Childhood Health:

❑ Chickenpox (age_____)
❑ German Measles (age_____)
❑ Red Measles (age_____)
❑ Rheumatic fever (age_____)
❑ Whooping Cough (age_____)
❑ Scarlet Fever (age_____)
❑ Autism
❑ Ear Infections
❑ Allergies to _____
❑ Chronic, serious health problems_____
_____

❑ Lead Poisoning (age_____)
❑ Mumps (age_____)
❑ Diphtheria (age_____)
❑ Poliomyelitis (age_____)
❑ Pneumonia (age_____)
❑ Tuberculosis (age_____)
❑ Mental Retardation
❑ Asthma

Any Delayed Developmental Milestones (Check only those milestones that did not occur at expected age)

❑ Sitting ❑ Rolling Over ❑ Standing ❑ Walking
❑ Feeding Self ❑ Speaking Words ❑ Speaking Sentences ❑ Controlling Bladder
❑ Controlling Bowels ❑ Sleeping Alone ❑ Dressing Self ❑ Engaging Peers
❑ Tolerating Separation ❑ Riding tricycle ❑ Riding Bicycle ❑ Playing Cooperatively

Your Social Interaction (Check all that apply)

❑ Normal social interaction ❑ Isolates self ❑ Very shy
❑ Alienates self ❑ Dominates others
❑ Associates with acting out peers ❑ Other_____

Your Intellectual/Academic Functioning (Check all that apply)

❑ Normal Intelligence ❑ High Intelligence ❑ Learning Problems
❑ Mild retardation ❑ Moderate retardation ❑ Severe retardation
❑ Authority conflicts ❑ Attention problems ❑ Underachieving
Current or highest educational level_____

Any Emotional or Behavior Problems (Check all that apply):

❑ Drug Use ❑ Repeats words of others ❑ Distrustful
❑ Alcohol Abuse ❑ Not trustworthy ❑ Extreme worrier
❑ Chronic lying ❑ Hostile/angry mood ❑ Self-injurious acts
❑ Stealing ❑ Indecisive ❑ Impulsive
❑ Violent temper ❑ Immature ❑ Easily distracted
❑ Fire-setting ❑ Bizarre behavior ❑ Poor concentration
❑ Hyperactive ❑ Self-injurious threats ❑ Often sad
❑ Animal cruelty ❑ Frequently tearful ❑ Breaks things
❑ Assaults others ❑ Frequently daydreams ❑ Disobedient
❑ Lack of attachment ❑ Other:_____

Describe any other developmental problems or issues:

_____
_____
_____
_____

Briefly describe your relationship with teachers, police or other authority figures.

_____
_____
_____
_____

Name:_____

How do you do in school? Do you have friends? Are you involved in activities? Are you motivated and hard working? Do you get into trouble or cut classes?

_____

_____

_____

_____

_____

_____

Behavioral Health Insurance Information

Insurance Company:
_____

Address of Insurance Company:_____

_____

Company Telephone#:_____Fax#_____

Policy Holder:
_____

Policy Holders Date of Birth:_____SS#_____

Policy Holders Driver's License:_____

Identification Number:_____

Group Number: _____

Name of Responsible Party_____

Client's SS#_____