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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 (□) areas of **abuse that you have encountered**: (□ Not applicable)

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

Please indicate (□) 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? _____