



Adolescent Information Form

To be completed by adolescent. Please answer all questions. Use the back to explain any answer. You will have a chance to explain any answer as this will be used as a starting point in our first session.

Name: _____	Today's date: _____
Nickname/Name you want to be called: _____	
Home Address: _____	
City: _____	State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____
Birth Date: _____	Age: _____ Gender: _____
Please enter complete e-mail address: _____	
Does anyone else have access to your e-mail address? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Living Arrangement

Parents One Parent Different according to time Guardian

Parent's/Guardian's Names: _____

Where do you go to school? _____

Highest Grade Completed _____

Are you employed/where? _____ Do you enjoy your job? Yes No

Did you participate in the decision to start counseling? Yes No

Previous History

Please describe what brings you to counseling at this time.

What do you hope to gain through counseling?

What have you already done to deal with the difficulties?

Have you had previous psychological counseling or psychiatric help? Please check all that apply.

Individual counseling

If yes, when and where did you receive counseling and what were the issues:

Group Counseling

If yes, when/where issues:

Hospitalization(s)

If yes, when/where issues:

Current Life Experiences

My favorite thing to do to pass the time is _____

The person I am most likely to talk to about my problems is _____

I have many friends that I spend time with. **Yes** **No**

I feel alone a lot of the times. **Yes** **No**

A lot of the time I feel (circle one) **angry** **sad** **guilty** **hurt** **frustrated**

If you could, what's the one thing you would change about your life? _____

Symptom Check List

Directions: Place a check next to any problems that are impacting your life. Next to the checkbox, rate how much it is affecting you on a scale of 1 – 10 with 1 meaning its impact on your life is very little, and 10 meaning its impact is tremendous.

<input type="checkbox"/>	Sleep changes (more/less)	<input type="checkbox"/>	Feeling Ignored or Abandoned
<input type="checkbox"/>	Bad dreams/nightmares	<input type="checkbox"/>	Thoughts of hurting self
<input type="checkbox"/>	Appetite changes (more/less)	<input type="checkbox"/>	Thoughts of hurting others
<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	Feelings of sadness/loss
<input type="checkbox"/>	Weight problems	<input type="checkbox"/>	Stress
<input type="checkbox"/>	Anxiety/tension/worry	<input type="checkbox"/>	Pain
<input type="checkbox"/>	Fear of dying	<input type="checkbox"/>	Fear of going "crazy"
<input type="checkbox"/>	Anger/frustration	<input type="checkbox"/>	Suspiciousness or mistrustfulness
<input type="checkbox"/>	Problems trusting others	<input type="checkbox"/>	Easily irritated/annoyed
<input type="checkbox"/>	Aggressiveness	<input type="checkbox"/>	Lying
<input type="checkbox"/>	Making/keeping friends	<input type="checkbox"/>	Arguing with others
<input type="checkbox"/>	Self injurious behaviors	<input type="checkbox"/>	Shyness
<input type="checkbox"/>	Unpleasant thoughts that won't go away	<input type="checkbox"/>	Bothered by recurring thoughts
<input type="checkbox"/>	Destruction of property	<input type="checkbox"/>	Use of alcohol
<input type="checkbox"/>	Use of drugs	<input type="checkbox"/>	Trouble with the law
<input type="checkbox"/>	Change in school performance	<input type="checkbox"/>	Victim of bullying
<input type="checkbox"/>	Trouble Concentrating	<input type="checkbox"/>	Trouble keeping still
<input type="checkbox"/>	Hear, see or smell things that aren't there	<input type="checkbox"/>	Difficulty following directions

