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**ADOLESCENT INFORMATION FORM**

Name \_\_\_\_\_ Date of 1<sup>st</sup> Appointment \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ ok to leave messages? Y/N

Mom Cell: \_\_\_\_\_ Dad Cell: \_\_\_\_\_ ok to leave messages? Y/N

**MEDICAL HISTORY**

Name of Primary Care Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: \_\_\_\_\_

Current medications being taken:

1) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

2) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

3) \_\_\_\_\_ Dosage/Freq \_\_\_\_\_ Start Date \_\_\_\_\_ Purpose \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Date of last medical evaluation: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems you experience: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**SCHOOL AND FAMILY HISTORY**

Do you experience any academic problems while in school? (Circle One) YES NO

If yes, please explain: \_\_\_\_\_

What was the last year of school you completed? \_\_\_\_\_ What school are you currently attending? \_\_\_\_\_

Who is in your current support network? (friends, relatives, other adults): \_\_\_\_\_

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

With whom do you live? Mother \_\_\_\_\_ Father \_\_\_\_\_ Stepmother \_\_\_\_\_ Stepfather \_\_\_\_\_ Guardian \_\_\_\_\_ Grandparent \_\_\_\_\_

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your relationship with your mother:

Currently: \_\_\_\_\_  
\_\_\_\_\_

In the past: \_\_\_\_\_  
\_\_\_\_\_

Describe your relationship with your father:

Currently: \_\_\_\_\_  
\_\_\_\_\_

In the past: \_\_\_\_\_

Describe your relationship with your stepmother: \_\_\_\_\_  
\_\_\_\_\_

Describe your relationship with your stepfather: \_\_\_\_\_  
\_\_\_\_\_

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse: \_\_\_\_\_  
\_\_\_\_\_

Sexual/physical/emotional abuse: \_\_\_\_\_  
\_\_\_\_\_

**MENTAL STATUS**

Please check any of the following that describe how you believe you feel:

sad  anxious  depressed  frightened  guilty  angry  ashamed  aggressive  resentful  
 worthless  tearful  irritable  confused  extreme ups/downs  jealous  hopeless  helpless  
 annoyed

Describe any other feelings you have had: \_\_\_\_\_

Please check any of the following risk-taking behaviors you have engaged in:

street racing  gang involvement  skip school  dropped out  dangerous dieting  cutting  stealing  
 unprotected sex  running away  bullying others  fire starting  hurt animals  restrict or restricted food intake  
 over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

beer  wine  hard liquor  pot  cocaine  heroin  Ecstasy  speed  over the counter drugs  
 prescription drugs  ice  Triple C's  dones  quad bars Other: \_\_\_\_\_

Have you had any change in sleeping habits? (Circle One) YES NO

Describe: \_\_\_\_\_

Have you had any change in eating habits? (Circle One) YES NO

Describe: \_\_\_\_\_

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: \_\_\_\_\_

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: \_\_\_\_\_

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: \_\_\_\_\_

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: \_\_\_\_\_

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: \_\_\_\_\_

**LEVEL OF FUNCTIONING**

List any current problems you are having in daily psychological, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members): \_\_\_\_\_

What activities or hobbies do you participate in? \_\_\_\_\_

Do you participate in regular exercise? (Circle One) YES NO

Describe: \_\_\_\_\_

How much time do you spend online or gaming? \_\_\_\_\_

Do you abuse laxatives, diuretics, or any type of diet pills? (Circle One) Yes/NO If no, have you used previously? (Circle One) Yes/No

Do you engage in any type of eating disordered behavior?

Binging                      Purging                      Overeating                      Restricting  
Exercising to Excess to account for Calories      Counting Calories      Constant Dieting  
Yo-Yo Dieting                      Having Calorie Goals

Do you engage in any type of self-Harm? If so, Please describe below.

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Rate your level of body satisfaction on a scale of 1-10 with 10 being the highest: \_\_\_\_\_

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

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Please list your therapy goals:

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THANK YOU!