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ADOLESCENT CLIENT INFORMATION FORM

Thank you for taking the time to complete the following forms, and any others that may be requested of you. The information you provide assists me in making a thorough and accurate assessment and to develop an individualized treatment plan to meet your needs.
The first forms are for the parent to fill out. There is a separate form indicated for the adolescent to fill out. The Adolescent can fill out the symptoms form first, and then make additions if you would like.

Today's Date: ____/____/____ Client's Date of Birth: ____/____/____

Client's Name: _____ Therapist's Name:_____
Client's Phone number: (C) _____
Client's mother's name: _____ Phone number: _____
Client's father's name: _____ Phone number: _____
Client resides with: ☐ mom and dad ☐ mom; when? _____
☐ dad; when? _____
If parents are divorced, who has the legal ability to initiate mental health services? _____
Which number would you prefer I call and best times: _____
Any restrictions for leaving messages at the above numbers? _____

Who referred you to this counselor for services? _____
May I have permission to thank this person/organization for the referral? □ Yes □ No
If yes, please leave a number they can be contacted. _____

1. Client's racial or ethnic origin (check one):
□ Native American □ Black/African American □ Caucasian/White
□ Asian/Pacific Islander □Hispanic/Latino □Multi-ethinic □Other

2. Spiritual Affiliation: _____
Would you consider your faith important in our work together? _____

3. The highest level of education that client has completed (check one):
□ No formal education □ Some grade school □ Complete grade school
□ Some high school

4. Parent(s) present employment status:
□ Employed full-time □ Employed part-time □ Unemployed
□ Full-time homemaker □ Retired □ Full-time undergraduate
□ Part-time student □ Full-time graduate student □ Other: _____

5. Your present annual family income (check one):
□ $0-7,999 □ $8,000-13,999 □ $14,000-20,999 □ $21,000-33,999
□ $34,000-42,999 □ $43,000-51,999 □ $52,000 and above

6. Client's parents are currently (check one):
□ Single □ Engaged □ Cohabitating □ Married □ Separated
□ Divorced □ Remarried

7. Current Household Composition and Immediate Family. (*Please include people in the adolescent's household as well as parent or siblings outside of the home*).

Name	Age	Relation to you	Occupation/School	In Home?

8. Did client ever experience or witness any physical, emotional, or sexual abuse in your past or current relationships? (***If yes, please discuss with this therapist.)*****_____**_____
_____

Presenting Problems

9. What is/are the reason(s) you are seeking therapy today? _____
_____

10. Did a specific event lead to this request for service? If yes, please describe the incident.
_____

11. Please describe what you hope to accomplish in this therapy or what you hope will be different in your life when this therapy is helpful to you? _____
_____

12. Has the client ever seen a counselor or therapist (e.g., psychiatrist, psychologist, social worker, clergy, family therapist) for emotional difficulties? □Yes □No
If yes, please list dates of counseling and reason(s) for contact, beginning with the most recent one.
_____
_____
_____

13. Please describe your past therapy experience.
_____
_____
_____

14. Are you currently involved with any other community-based support groups (e.g., 12-step groups, social support groups) or seeing someone else regarding mental health concerns?
□Yes What/Whom? _____
□No

15. Has the client ever attempted to harm himself/herself through cutting or other self-injurious behavior?

If yes, how many times and how recently? _____

16. Does client have any history of suicidal thought, plan, or intent? _____

17. Does client currently have any suicidal thought, plan, or intent (***If yes, please discuss with therapist)***?
_____

18. Is client currently taking any medications? (***If yes, please list)***
Medication _____ Dosage _____
Medication _____ Dosage _____
Medication _____ Dosage _____

Clinic/Doctor's Name: _____
Phone Number: _____
Address: _____

19. List any significant health problems, past or present, including surgeries or illness.
_____

20. Date of client's last physical exam. _____/_____/_____

21. Was there any chemical use during the pregnancy with client?
_____

22. Has client experienced any significant head injuries? When? _____
Treatment given? _____

23. How would you describe client's friendships and how they interact socially?
_____

24. What have the teachers' reports of your child's performance at school? Any concerns?
_____

Below is space for you to share any further information you feel would be helpful for me to know in helping your child:
_____
_____
_____
_____
_____
_____
_____
_____
___

PLEASE CONTINUE ONTO THE NEXT PAGE. THE FOLLOWING INFORMATION WILL BE COMPLETED BY YOUR ADOLESCENT.

THE FOLLOWING QUESTIONS ARE TO BE FILLED OUT BY THE ADOLESCENT

25. What is the reason for you coming to therapy/counseling?

_____

_____

26. Did something specific happen that brought you here today?

_____

_____

27. What do you hope to get out of counseling?

_____

_____

28. What do you consider your greatest strengths and your biggest struggles?

_____

_____

29. Please check yes or no to the following (adolescents):

	Yes	No
1. Have you ever felt you should cut down on your drinking/chemical use?		
2. Have people annoyed you by criticizing your drinking/chemical use?		
3. Have you ever felt bad or guilty about your drinking/chemical use?		
4. Have you ever had a drink/used first thing in the morning to steady your nerves or get rid of a hangover?		

30. Please describe your use of the following substances (adolescents):

	Daily	Weekly	Occasionally	Not at all
Caffeine				
Tobacco				
Alcohol				
Prescription Drugs				
Street Drugs				
Over the Counter Medication				

Thank you very much for taking the time to share this personal information. It will greatly help me in your assessment and treatment process. If there is anything else you would like to add, please feel free to include below or discuss during our meeting.