

Confidential Adolescent Information Form

Name: _____ Today's Date: _____

Nickname/Name you want to be called: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender (M/F): _____

Home Phone: _____ Cell Phone: _____

School: _____ Grade: _____

Present Living Arrangement:

Parents One Parent Grandparent Guardian Other _____

Parent's/Guardian's Name and relationship to you:

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Are you employed? Yes No Where? _____

Do you participate in extracurricular activities? Yes No

If yes, what are they?

What is your current average grade in each of the following subjects?

English _____ Math _____ Science _____ History _____

Please list other classes you are presently taking and your current average

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

Have you ever been in counseling before? Yes No If yes, when? _____

Please describe what brings you to counseling at this time. _____

What have you already done to deal with the difficulties? _____

What do you hope to gain through counseling? _____

How would you rate your current physical health? Excellent Good Fair Poor

Are you currently experiencing any physical problems (e.g~ headaches, body aches)

Yes No

If yes, please explain: _____

List any serious or chronic illnesses, operations, or traumatic accidents you have had:

List any medications and dosages you are taking:

Medication

Dosage

_____	_____
_____	_____
_____	_____
_____	_____

What are your biggest strengths? _____

Do you exercise? Yes No

If yes, how many times per week? _____ For how long? _____

Do you smoke cigarettes: Yes No

If yes, how many per day? _____

Do you consume alcohol? Yes No

If yes, how many drinks per day? _____ week? _____

Do you take any recreational drugs? Yes No

What kind? _____

How many times per day? _____ week? _____

PROBLEM CHECKLIST

Please rate each issue with a number 1, 2, or 3

1 = Major Problem 2 = Sometimes a problem 3 = Never a problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Feeling bad about the way I look/my body

_____ Getting along with my parents or other family members

_____ Getting a clear sense of what I value

_____ Worrying about whether I'm normal

_____ Dealing with sexual feelings and/or problems

_____ Excessive worry or anxiety

_____ Trying to decide on a career

_____ Never eating/eating too much and vomiting to control weight

_____ Dealing with my alcohol or drug abuse

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

_____ Thinking about killing myself

_____ Wanting to hurt someone else

_____ Not being able to sleep at night

Are there any other problems or concerns you would like to address? _____