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Adolescent Form:

Name: _____ Birth date: _____ Date: _____

Describe the problem(s) that brought you here today:

Personal Information:
How would you describe yourself?

Check any of the symptoms that you are having:

- ❑ Depressed mood every day/nearly every day
- ❑ Extreme sadness
- ❑ Trouble concentrating
- ❑ Memory problems
- ❑ Change in eating habits
- ❑ Feeling of extreme happiness
- ❑ Trouble performing your job
- ❑ Lack of enjoyment of usual activates
- ❑ Self-esteem problems
- ❑ Perfectionism
- ❑ Obsessions or compulsions
- ❑ Feeling fearful
- ❑ Physical complaints of pain
- ❑ Problems with anger
- ❑ Feeling hopeless
- ❑ Feeling tearful
- ❑ Change in sleeping habits
- ❑ Lack of energy
- ❑ Weight changes
- ❑ Excessive anxiety or worry
- ❑ Problems getting along with friends or family
- ❑ Feeling stressed
- ❑ Easily irritated
- ❑ Feeling guilt
- ❑ Feeling nervous
- ❑ Sudden feelings of panic
- ❑ Muscle tension
- ❑ Acting violently

Have you ever thought of hurting yourself?
If yes, do you have a plan?

Have you ever thought of hurting someone else?
If yes, do you have a plan?

Received by: _____ Date: _____

Stressful Circumstances:
Have you experienced any stress recently? (Examples: conflict with family/friend, financial problems, death, divorce, and illness)

If yes, please explain when and what.

Have you ever been physically abused?

If yes, is it still going on?

Have you ever been sexually abused?

If yes, is it still going on?

Medical and Health Information:

How would you describe your diet?

- ❑ Healthy (I eat pretty good)
- ❑ Average (I probably need to change some things)
- ❑ Needs some help (I eat a lot of junk)

How often do you exercise?

- ❑ Daily
- ❑ 3-5 times a week
- ❑ 1-2 times a week
- ❑ Less than once a week

Previous and current health problems or illnesses:

Previous and current medications:

Social & Academic Information:

<u>School:</u>
What school do you go to?
Grade level/year:

What classes do you like?

Received by: _____ Date: _____

What classes don't you like?

How are your grades?

Are you involved in any school activities?
If yes, what:

Do you have problems in school?
If yes, what are they:

Work:
Where do you work?

Do you have any problems there?

Friends:
Who are your close friends?

Do you have a serious one-on-one relationship now?

Family Information:

Parents' (please list names, ages, and where they are currently living)

How would you describe your parents' relationship?

Are you adopted?

How many siblings do you have? (Please list names, ages, and where they live now)

Received by: _____ Date: _____

Describe your relationship with the following:

Parents/step-parents/guardians:

Brothers and/or sisters:

Extended family (grandparents, aunts, uncles, cousins)

Family History:
Has any family member had any of the following? If yes, who, when and how treated?

Anxiety/Panic _____
Obsessions/Compulsions _____
Substance abuse _____
Depression/mood swings _____
Anger/aggression _____
Schizophrenia _____
Suicidal Behavior _____
Other conditions? _____
Any major illness _____

Additional Information:

What worries or upsets you?

What makes you happy?

What would you like to see happen or change because of this counseling?

Received by: _____ Date: _____