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Teen 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:

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

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:

Do you have any current or past medical problems?

Have you done counseling or family counseling before?

Do you take any medications?

If yes, please list

How would you describe your eating habits? (healthy, average, needs some help)

How often do you exercise? What type of activities do you do?

How would you describe your sleeping habits? How many hours of sleep do you typically get?

Academic & Work Information:

School:

What school do you go to?

Grade level/year:

What classes do you like?

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?

Friendships/support & activities:

Do you have a strong support group or friendships?

Who are your close friends?

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

If yes, how would you describe it?

What are some of the hobbies or activities that you enjoy? Do they help decrease stress?

Social Media/Electronics:

How often do you use the computer or electronics?

What type of things are you doing on the computer? (ie. Video games, visiting certain sites, homework, email.)

Do you have your own phone?

If yes, how often are you on it? How would you feel if you lost it?

Do you have a twitter, Instagram, facebook or other social media account?

Do you ever feel sad or worried if you aren't connected to friends through your social media accounts?

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)

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?