This form to be completed by Teen Client

Date completed___________________

Name:_______________ DOB:_______Age:____Grade:_____School:____________
(13-18 yrs old)

1. PRESENTING PROBLEM

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

Check any of the symptoms that you have been having:

Symptom		Symptom	
Depressed mood		Feels hopeless	
Extreme sadness		Tearful/crying spells	
Trouble concentrating		Memory problems	
Change in sleeping habits		Lack of energy	
Anorexia/Bulimia		Drug Use	
Anxiety		Nightmares	
Problems getting along with family		Weight/appetite changes/ concerns	
Doesn't seem to enjoy usual activities		Problems getting along with friends	
Trouble doing schoolwork		Feelings of extreme happiness	
Feeling stressed/nervous		Truancy/Legal/Court	
Low self-esteem		Irritability	
Perfectionistic		Isolation/withdrawal	
Worry (chronic)		Expresses feelings of guilt	
Feeling fearful		Obsessions (thoughts that won't go away)	
Physical complaints of pain		Sudden feelings of panic	
Anger outbursts		Tense/uptight	
Running away		Acting violently	
Has hurt or cut on self		Harm to animals	
Suicidal feelings		Fire setting	
		Thoughts of killing others	

(This space reserved for additional comments by clinician)

Appetite (circle): Good Fair Poor

Probation Officer:__________________

Strengths:

Continue on the other side

Name:______________________________

2. WHAT HAS BEEN DONE ABOUT THIS PROBLEM SO FAR?

Have you or your parents worked with a teacher or school counselor? Yes No

If you have, please describe it below.

Name of teacher or counselor: Date(s): Was this helpful to you?

3. Have you been in counseling before? Yes No

If you have been in counseling before, please describe it below, starting with the most recent first.

A. Date of most recent counseling:
Name of counselor:
Explain what happened: Was this helpful to you?
B. Date of other counseling:
Name of counselor:
Explain what happened: Was this helpful to you?

4. Have you <u>ever</u> been prescribed any PSYCHIATRIC medications including medications for anxiety, depression or ADD/ADHD? Yes No

If yes, please describe: Medication name: Reason: Date(s): Who prescribed:

5. SUBSTANCE USE HISTORY (If Applicable) **CHECK HERE IF N/A**

Do you use tobacco (any form)?	Current Describe:	Past	No
Do you use alcohol?	Current Describe:	Past	No
Do you use caffeine (any form, including cola, coffee or energy drinks)?	Current Describe:	Past	No
Do you use recreational drugs?	Current Describe:	Past	No

Continue on next page

Name:______________________________

6. MEDICAL INFORMATION

Have you seen a doctor or nurse within the last year? If yes, see below. **Yes** **No**
Reason for visit: Who did you see?
Who is your current healthcare provider? Phone:
Are you taking any medications, prescription or over-the-counter including medication for allergies, skincare, etc? **Yes (see below) No**
Please list any medication(s) and dosage that you are taking: Medicine: Dosage:
Please list any major **MEDICAL** problems that you have had such as chronic illness, serious illness, operations, injuries or trauma to the head, etc:
Describe any allergy problems that you have***, including food allergies***:
Sleep Pattern (Circle all that apply): *No Problem* *Problems falling asleep* *Early wakening* *Frequent Wakening* *Non-restful* *Too much* *Too little* *Disturbing dreams*
Have you been affected by any issues such as witnessing violence, having accidents, experiencing loss or experiencing abuse (physical, sexual, or emotional)? **Yes** **No** Please describe the relevant issue(s)

7. OTHERS LIVING IN THE HOME

Name:	Age:	Relationship to client:

8. DEVELOPMENTAL HISTORY (*Ask a parent or guardian about this information)

*Any problems with the pregnancy or delivery of the teen? Explain:
*Any substance use or abuse issues in the family? Explain:
*Any mental health problems in the family of origin? Explain:
Has there been any family crisis such as marital separation or divorce? Explain:
Briefly describe your relationship to parents or guardians:
Briefly describe your relationship to siblings (indicate if full, half or step):
Briefly describe your temperament (moods):

9. SCHOOL HISTORY

At what age did you start school? If there any problems at that time, explain:
What problems have come up during the school years? Learning disability?__________ Detention____________ Suspension/Expulsion________________ IEP/504 plan?_____________
Your current grades/which classes: Indicate which are your favorite classes or those you have problems with.
Describe any changes in your school performance:
Describe how you get along with your teachers: Do you have a favorite teacher or someone who supports your efforts in school? Explain:
Describe how you get along with your friends or peers at school:
What are your extra curricular activities? What do you like to do when not attending school?
Is there anything else you would like to add?