



Client Name: \_\_\_\_\_  
File # \_\_\_\_\_

## COUNSELING New Client Form (Adolescent)

Date \_\_\_\_\_

Instructions: Please complete this form to the best of your ability with the information you have available to you at this time. Do your best to answer each item as fully as you can. ***It is highly recommended that this form be completed with information developed in cooperation with the adolescent, if possible.***

### General Client Information

Adolescent's Name \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Parent/Guardian Home Phone: \_\_\_\_\_ Parent/Guardian Work Phone: \_\_\_\_\_

Parent/Guardian Cell: \_\_\_\_\_ Email address: \_\_\_\_\_

May we contact you via:  Home Phone  Cell Phone  Work Phone  Email (email is non-secure)

Other: \_\_\_\_\_ May we leave a Voice Message?  YES  NO

Other Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Adolescent's Place of Birth: \_\_\_\_\_ Ethnic/Cultural Background: \_\_\_\_\_ Religion: \_\_\_\_\_

Native Language: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Occupation: \_\_\_\_\_ Annual Income: \_\_\_\_\_ Employer: \_\_\_\_\_

Referred by: \_\_\_\_\_ May I thank this referral source for directing you to this practice?  Yes  No

### Health Insurance Information

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Co Pay: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Date of Birth of Subscriber: \_\_\_\_\_ Relation to Client: \_\_\_\_\_

Place of Employment of Subscriber: \_\_\_\_\_

### Current Issues

Please provide a brief description of why you are seeking counseling/therapy services for your adolescent:

• Has anything happened that may have brought on/intensified your adolescent's problems?  Yes  No  
If yes, please explain:

• When (month/year) did your adolescent first begin to experience these problems? \_\_\_\_\_

• How many days, weeks, months, or years has your adolescent been experiencing these problems?  
\_\_\_\_\_



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### COUNSELING

- How often does your adolescent experience these problems? (check the one that best describes your adolescent's current experience).
  - Most of the day, every day
  - Some part of the day, every day
  - Most of the day on most days
  - Some part of the day on most days
  - More than once a week
  - More than once a month
- How much is/are the problems affecting your adolescent?     Mildly     Moderately     Severely
- In what areas do your adolescent's problems impact his/her life? (Check all that apply)
  - Lifestyle (the way your adolescent lives his/her life)
  - Activities (things your adolescent normally does or would like to do)
  - Relationships (your adolescent's ability to form or maintain relationships with others)
  - Eating
  - Sleeping
  - Mood
- Has your adolescent ever attempted suicide?     Yes     No                      If yes, when? \_\_\_\_\_
- Has your adolescent been thinking about suicide?     Yes     No
- Has your adolescent ever thought about harming or killing someone else?     Yes     No If yes, when? \_\_\_\_\_  
Has your adolescent been thinking about harming or killing someone else?     Yes     No



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#### Adolescent Problems Checklist: Check all that apply (to be completed by both the adolescent and parent/guardian)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Depression                                 | <input type="checkbox"/> Heart racing                            | <input type="checkbox"/> Excessive behaviors<br>(Examples: spending,<br>gambling)                                | <input type="checkbox"/> Losing track of time                         |
| <input type="checkbox"/> Low energy                                 | <input type="checkbox"/> Chest pain or heaviness                 | <input type="checkbox"/> Delusions/hallucinations<br>(Thinking/believing or<br>seeing/hearing unusual<br>things) | <input type="checkbox"/> Problems with memory                         |
| <input type="checkbox"/> Low self-esteem                            | <input type="checkbox"/> Chills/hot flashes                      | <input type="checkbox"/> Sexual problems/behavior  | <input type="checkbox"/> Unpleasant thoughts that<br>won't go away    |
| <input type="checkbox"/> Poor concentration                         | <input type="checkbox"/> Tingling/numbness                       | <input type="checkbox"/> Self injurious behaviors  | <input type="checkbox"/> Bothered by recurring<br>thoughts            |
| <input type="checkbox"/> Lack of interest/enjoyment<br>in life      | <input type="checkbox"/> Pain                                    | <input type="checkbox"/> Shyness   | <input type="checkbox"/> school/educational<br>problems or indecision |
| <input type="checkbox"/> Feeling hopeless                           | <input type="checkbox"/> Fear of dying                           | <input type="checkbox"/> Social skills   | <input type="checkbox"/> Destruction of property                      |
| <input type="checkbox"/> Feeling worthless                          | <input type="checkbox"/> Fear of going "crazy"                   | <input type="checkbox"/> Social support<br>(family/friends)  | <input type="checkbox"/> Self-criticism                               |
| <input type="checkbox"/> Feeling guilty or shameful                 | <input type="checkbox"/> Nausea                                  | <input type="checkbox"/> Stealing  | <input type="checkbox"/> Family problems                              |
| <input type="checkbox"/> Sleep changes<br>(more/less)               | <input type="checkbox"/> Fears or phobias                        | <input type="checkbox"/> Strange, weird, or peculiar<br>behavior   | <input type="checkbox"/> Marital/relationship<br>problems             |
| <input type="checkbox"/> Loneliness                                 | <input type="checkbox"/> Obsessions/compulsions                  | <input type="checkbox"/> Confusion/can't think<br>clearly  | <input type="checkbox"/> Parent/child problems                        |
| <input type="checkbox"/> Bad dreams/nightmares                      | <input type="checkbox"/> Thoughts racing                         | <input type="checkbox"/> Feeling "not real"  | <input type="checkbox"/> Use of alcohol                               |
| <input type="checkbox"/> Feeling Ignored or<br>abandoned            | <input type="checkbox"/> Disorganization                         | <input type="checkbox"/> Feeling detached from<br>yourself   | <input type="checkbox"/> Use of drugs                                 |
| <input type="checkbox"/> Appetite changes<br>(more/less)            | <input type="checkbox"/> Procrastination                         | <input type="checkbox"/> Feeling "hyper"   | <input type="checkbox"/> Blackouts                                    |
| <input type="checkbox"/> Mood swings                                | <input type="checkbox"/> Can't hold onto an idea                 | <input type="checkbox"/> Financial problems  | <input type="checkbox"/> Physical abuse                               |
| <input type="checkbox"/> Thoughts of hurting self                   | <input type="checkbox"/> Anger/frustration                       | <input type="checkbox"/> Grief/bereavement   | <input type="checkbox"/> Sexual abuse                                 |
| <input type="checkbox"/> Thoughts of hurting others                 | <input type="checkbox"/> Suspiciousness or<br>mistrustfulness    | <input type="checkbox"/> Health problems   | <input type="checkbox"/> Partner abuse                                |
| <input type="checkbox"/> Isolating from<br>others/social withdrawal | <input type="checkbox"/> Problems trusting others                | <input type="checkbox"/> Impact of your problems<br>on others  | <input type="checkbox"/> Trouble with the law                         |
| <input type="checkbox"/> Feelings of sadness/loss                   | <input type="checkbox"/> Easily irritated/annoyed                |  | <input type="checkbox"/> Experienced/witnessed<br>trauma              |
| <input type="checkbox"/> Weight problems                            | <input type="checkbox"/> Aggressiveness                          |  | <input type="checkbox"/> Loss/death of someone<br>close               |
| <input type="checkbox"/> Stress                                     | <input type="checkbox"/> Perfectionist behavior                  |  | <input type="checkbox"/> Impulsive behaviors                          |
| <input type="checkbox"/> Anxiety/tension/worry                      | <input type="checkbox"/> Lying                                   |  | <input type="checkbox"/> Other (please describe):                     |
| <input type="checkbox"/> Panic attacks                              | <input type="checkbox"/> Making/keeping friends                  |  |   |
|   | <input type="checkbox"/> Arguing with others                     |  |   |
|   | <input type="checkbox"/> Performing unusual rituals<br>or habits |  |   |
|   | <input type="checkbox"/> Impulsiveness                           |  |   |

#### Impact of Teen's Problem on Family: (to be completed by parent or guardian)

Teen's Name: \_\_\_\_\_ File # \_\_\_\_\_ Date: \_\_\_\_\_

Person completing checklist: \_\_\_\_\_

#### Rating Scale

Read each of the items below. Write in the number that corresponds with the level of impact your child's problem has in each area.

- 0 **No impact in this area**
- 1 **Slight impact in this area**
- 2 **More than slight impact, but less than moderate impact**
- 3 **Moderate impact**
- 4 **More than moderate impact**
- 5 **Serious impact**



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#### Areas of Family Life

1. Time mother spends with the other children in the family	11. Visiting friends in their homes
2. Time father spends with the other children in the family	12. Emotional well-being of mother
3. Amount of time mother spends with father	13. Emotional well-being of father
4. Amount of time father spends with mother	14. Emotional well-being of brother(s) and sister(s)
5. Family time spent with relatives	15. Family finances
6. Going out to eat as a family	16. Relationship between parents
7. Going out as a family other than to eat (e.g., shopping, church, movies)	17. Relationships among the children of the family
8. Going on a family vacation	18. Relationship between patient and parents
9. Having friends visit our home	19. Relationship between parents and the other children of the family
10. Mealtimes	20. Spending leisure time together

#### Current Life Experiences

- My adolescent lives in:  Apartment  House  Condo/Townhouse  Mobile Home  Rooming House  Other

- My adolescent lives with:

Name	Age	Relationship to child	Problems

- Other significant persons in my adolescent's life who do not live with him/her include:

Name	Age	Relationship to me	Problems	Resides where?

#### Problems or changes in my adolescent's family or other important interpersonal relationships:

Date(s)	Persons Involved	Relationship to me	Problems or Changes



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**COUNSELING**

Problems or changes in educational, social, or recreational functioning:

Date(s)	Problems or Changes
_____	_____
_____	_____
_____	_____

My adolescent's sources of satisfaction:

\_\_\_\_\_

- My adolescent's sources of stress:  
\_\_\_\_\_
- My adolescent's leisure activities:  
\_\_\_\_\_
- My adolescent's typical day is as follows (attach extra sheets, if necessary):  
\_\_\_\_\_

• History of Counseling or /Therapy:

- Is your adolescent currently being treated by a counselor, psychologist, psychiatrist, and/or other physician for the problems noted above?  Yes  No If yes, please provide the following information:

Date(s) etc.)	Name of Professional	Address	Treatment Type (counseling, therapy, medication, etc.)
_____	_____	_____	_____
_____	_____	_____	_____

- Please provide information regarding previous treatment your adolescent has received from a counselor, psychologist, psychiatrist, or other medical or mental health professional for this or other problems:

Date(s)	Name of Professional	Address	Treatment Type	Why treatment ended
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



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**COUNSELING**

Has your adolescent ever been hospitalized for treatment of an emotional or mental disorder?

Yes  No If yes, please provide the following information:

Date(s)	Name of Hospital or Facility	Address	Reason for Hospitalization
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**Medical History**

• Please complete the information below regarding past and current medical conditions and treatment:

Date(s)	Physician Name / Address	Condition	Treatment	Results
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Please list any allergies/sensitivities/drug reactions:

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• Please list all current prescription and over the counter medication use:

Beginning (date)	Medication	Dose	Frequency of use	Condition Treated
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Please list any previous prescription and over the counter medication use

Date(s)	Medication	Dose	Frequency of use	Condition Treated
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From _____ To _____				
From _____ To _____				
From _____ To _____				
From _____ To _____				



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- Please list any current or previous use of street drugs, tobacco products, or alcohol:

Date(s) applicable)	Type Used	Frequency of Use	Amount Typically Used	When ended (if applicable)
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- Please list any hospitalizations or surgeries:

Date(s) Treatment/Surgery	Hospital/Facility	Physician	Condition	Type
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### Family of Origin

- Please list the members of your adolescent's family of origin in the order that they were born. Include current ages. Example: Maternal grandmother (deceased), Mother (age 37), father (age 36), sister Anne (age 17), client (age 15), brother Larry (age 10)

- Please describe the background or status of your adolescent's family of origin for the following categories:

Ethnic:  
\_\_\_\_\_

Religious:  
\_\_\_\_\_

Social:  
\_\_\_\_\_

Financial:  
\_\_\_\_\_

- Briefly describe any of the following that apply to your adolescent's family of origin:

- Crisis or other significant events:
- Any emotional, psychological, or physical illness: (Examples: cancer, diabetes, heart disease, depression, alcoholism, drug abuse or addiction, family violence, depression, suicide)
- Parenting styles of your adolescent's mother, father, and other caretakers? Who does what and how?
- Communication styles in your adolescent's family of origin? Who does most of the talking, teaching, and connecting?



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- Your adolescent's relationship with his/her:

Mother:

Father:

Stepparent:

Grandparents

Siblings:

Other significant family members:

Friends:

Teachers:

Other significant persons:

### Developmental History

Briefly describe your adolescent's (1) physical, (2) psychological, (3) emotional, (4) intellectual, (5) social, (6) spiritual, and (6) academic development, and (7) any significant experiences affecting you child during the following stages of his/her life (attach extra sheets, if needed):

- Prenatal development and infancy (conception up to age 2):
- Early Childhood (age 2 through age 5):
- Middle and Late childhood (age 6 through age 11):
- Adolescence (age 12 through age 18)

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Adolescent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_