Kelly A. Martin Counseling, PLLC
Dba: Sonshine Soul-utions Counseling

Personal History – Adolescent:

Client name: _____ Date: _____

Gender: _____ Date of birth: _____ Age: _____

Form completed by (if someone other than client): _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (home/cell) _____

Alternate phone: _____ Email: _____

May I leave voice mail message on your phone(s)? Yes No

Emergency contact name: _____ Phone: _____

Primary reason(s) for seeking services: (Circle all that apply)

Addictive/Risky Behaviors	Alcohol/Drugs	Anger Management	Anxiety
Depression	Domestic Violence	Fear/Phobia	Family Issues
Grief	Post Trauma Stress	Relationship Issues	Sexual Assault
Teen Group	Time Management	Other: _____	

Family Information – Living in Your Home:

Relationship	Name	Age

Other significant relationships in your life that need to be included or mentioned:

Relationship Name Age (Please note if deceased, and also cause of death)

_____

_____

_____

Relationship Status:

Single In A Dating Relationship Other

Comments / Explanations: _____

Assessment of current relationship (if applicable): Good Fair Poor In Danger

Development: Are there special, unusual, or traumatic circumstances that affected your development? _____

If yes, please describe: _____

_____

Has there been a history of child abuse? Yes No

If yes, which type(s) Sexual Verbal Physical

If yes, the abuse was as a(n) Victim Perpetrator

Other childhood issues: Neglect Inadequate Nutrition Other: _____

_____

_____

_____

Social Relationship Descriptors - Check how you generally get along with others: (Check all that apply)

Affectionate	Aggressive	Avoidant	Argue/Fight Often
Follower	Friendly	Leader	Outgoing
Shy/Withdrawn	Submissive	Other: _____	

_____

Have you been a victim of bullying? _____ If yes, please describe: _____

_____

_____

Cultural/Ethnicity: To which cultural or ethnic group, if any, do you belong? _____

Are you experiencing any problems due to cultural or ethnic problems? Yes No

If yes, describe: _____

Spirituality/Religion: How important are spiritual matters to you? _____

Are you affiliated with a spiritual or religious group? Yes No

If yes, please describe: _____

Would you like your spiritual/religious beliefs incorporated into your counseling? Yes No

Comments: _____

_____

Legal Issues - Current Status: Are you involved in any active cases (traffic, civil, criminal) Yes No

If yes, please describe reason/charges: _____

Are you currently on probation or parole? Yes No

If yes, please describe: _____

Past history – Criminal involvement:

Charge/Reason Date City Results

_____

_____

Education - Highest level of school completed: _____

Comments: _____

_____

Employment - Describe most recent job and history:

Employer	Dates	Duties/Title	Reason for Leaving

Leisure/Recreational – Describe special areas of interest/hobbies: (art, crafts, sports, church, exercise, etc.)

Activity	How often now?	How often in past?

Medical/Physical Health – Put an "S" beside items that apply to you and an "F" applying to a family member.

_____Allergies	_____Eating Problems	_____Sleep Disorders	_____Anemia
_____Surgery	_____Fatigue	_____Cancer	____Headaches
_____Diabetes	_____Blood Pressure	_____Mental Disorder	____Loss of Hearing
_____Chronic Pain	____Vision Problems	_____Loss of Memory	Other:

_____

Current health concerns: _____

Current prescribed medications	Dose	Purpose	Side effects

Are you allergic to any medications or drugs?_____

Please circle if there have been any recent changes in the following:

Sleep Patterns | Eating Patterns | Behavior | Energy Level

Physical Activity Level | General Disposition (Mood) | Weight | Nervousness/Tension

Describe changes in areas checked above: _____

_____

Chemical Use History: Method & Amount | Frequency | Age of 1st Use | Date of Last Use

Alcohol: _____

Cocaine/Crack: _____

Heroin/Opiates: _____

Inhalants: _____

Marijuana: _____

Methamphetamines: _____

Prescription Drugs/Other Drugs: _____

Tobacco/Nicotine: _____

Substance Abuse Questions – Do you abuse or are you addicted to any substance? Yes No

If yes, describe: _____

_____

Counseling/Prior Treatment History – Have you ever sought counseling before? Yes No

If yes, what was the experience like for you? _____

_____

Have you ever experienced suicidal thoughts or attempted suicide? Yes No

If yes, please describe: _____

_____

Have you ever had any type of inpatient treatment (including drug/alcohol rehab)? Yes No

If yes, please describe: _____

_____

Do you have any family members or friends who have been treated for suicidality or addiction? Yes No

If yes, please describe:_____

_____

Please circle behaviors and symptoms that occur to you more often than you would like:

Aggression/Anger	Anxiety	Gambling	Sexual Addiction	Antisocial Behavior
Hallucinations	Worrying	Loneliness	Eating Problems	Withdrawing
Mood Shifts	Crying	Sickness	Avoiding People	Nightmares
Hopelessness	Chest Pains	Impulsivity	Depression	Suicidal Thoughts
Sexual Dysfunction	Panic Attacks	Drug Use	Judgment Errors	Irritability
Cyber Addiction	Memory Trouble	Other symptoms? _____		

Describe which symptom(s) impact you the most: _____

_____

What is your hope for coming to counseling? _____

_____

Other information I need to know? _____

_____

_____

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date