northwinds
counseling services, p.a.

21395 John Milless Drive I Suite 400 I Rogers, MN 55374
Phone: 763.424.1888 I Fax: 763.424.7288
www.northwindscounseling.com

Personal History Form – Minor

Client name:_____Age:_____D.O.B._____Gender: M F

Primary reason(s) for seeking services:

_____Depression _____Anxiety _____Alcohol/drugs _____Anger management
_____Coping _____Fear/phobias _____Behavior Problems _____Martial issues/conflict
Other _____

Please circle behaviors and symptoms that are problematic:

Aggression	Worrying	Hallucinations	Attention Deficit
Anxiety	Heart Palpitations	People avoidant	Trouble concentrating
Depression	Recurring thoughts	Disorientation	Sexual problems
Alcohol problems	Irritability	Cyber addiction	Antisocial behavior
Fatigue/Tired	Impulsivity	Speech problems	Sleep problems
Panic attacks	Distractibility	Gambling problems	Fears/phobias
Anger	Chest pain	Sick often	Self-injury/behavior
Hopelessness	Loneliness	Alcohol/Drug issues	Memory problems
Suicidal thoughts	Mood swings	Eating issues	Withdrawing/isolating

Does the minor report feel suicidal at this time? Yes or No
Does the minor report have a plan for suicidal? Yes or No
Please include any additional information that would assist us in understanding your concerns and problems?

_____
_____
_____

Has the minor recently experienced any that follow?

Recent death or birth in the family	Accident, fire, disaster	Separation or divorce
Job loss or change	Arrest or DUI	Major Financial Problems
Change in living arrangements	Physical/emotional abuse	Sexual abuse or assault
Thoughts/acts of violence to others	Thoughts/acts of hurting self	Custody issues
Pregnancy, miscarriage, abortion	Diagnosis of major illness	Significant relationship discord

Parental Information (circle)

Parents legally married Parents never married Parents divorced at what age (yours) _____
Special circumstances (e.g., raised by person other than parents, information about spouse/kids not living with you etc.): _____

Developmental history

Has there been a history of child abuse? Yes or No If yes, which type: ___Sexual ___Physical ___Verbal
Other childhood issues: ___Neglect _____Exposure to trauma _____Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain _____

Social Relationships

Circle how the minor generally gets along with other people:

Affectionate	Aggressive	Avoidant	fight/argue often	Follower
Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

What is the minor's sexual orientation? _____

Have you experienced any Sexual dysfunctions? Yes or No

Spiritual/Religious

Is the minor connected with a spiritual or religious group? Please Explain_____
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal

Are you involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges _____
Are you currently on probation or parole? Yes or No
Have you been accusations of any sexual crimes? Yes or No

Education, Employment, Military (circle)

Education: Currently enrolled in school High school grad/GED Vocational School
Some College College Graduate Masters or Doctorate
Any learning disabilities: Yes or No If yes, please explain _____

Employment: Current employer _____

Fulltime	Part time	Temp	Laid-off	Disabled	Retired	Social Security
Job satisfaction:		poor	good	fair	great	

Military experience? Yes or No Combat experience? Yes or No Service length _____
Where:_____Branch:_____Type of discharge _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling sports, etc.)

_____

_____

Medical/Physical Health

phone _____
Primary care Doctor _____

List any current health conditions you have and any recent health changes: _____
Are you currently using any prescribed medications: _____

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

Sleep patterns Eating Patterns Behavior Energy Level Physical activity level

General Disposition Weight Nervousness/tension

Others: _____

Chemical use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Use in last 48 hours	Used in last 30 days
					yes	**yes**
Alcohol					**yes**	**yes**
Cocaine/Crack					**yes**	**yes**
Meth					**yes**	**yes**
Marijuana					**yes**	**yes**
Valium/Librium					**yes**	**yes**
Heroin/Opiates					**yes**	**yes**
PCP/LSD/Mescaline					**yes**	**yes**
Inhalants					**yes**	**yes**
Caffeine					**yes**	**yes**
Nicotine					**yes**	**yes**
Pain killers					**yes**	**yes**

Drug of choice

How does your use affect your life? _____

Has anyone expressed concern about your use? Yes or No

Are you concerned about your use? Yes or No

Are there presently or past history of a family member having problems with drugs or alcohol? Yes or No

Consequences experienced because of your use? Legal, relational, physical, mental, job, financial

Please explain: _____

Counseling Prior Treatment History

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Care	_____	_____	_____	_____
Suicidal thoughts/attempts	_____	_____	_____	_____
Drug/alcohol treatment	_____	_____	_____	_____
Hospitalizations	_____	_____	_____	_____

Is there a family history of mental illness or substance abuse problems? _____

Please list treatment goals wished to accomplish.

Thank you for your time completing the questionnaire.

ADOLESCENT BEHAVIOR CHECKLIST

Name: _____ DOB: _____ Date:_____

	ATTENTION		**CONDUCT**
	Makes careless mistakes		Stolen items
	Attention Span is Poor or limited		Forces sexual activity
	Doesn't listen to simple instruction		Deliberately sets fires
	Avoids tasks requiring concentration		Lies or cons
	Doesn't finish tasks to complete		Broken into property
	Problems organizing self		Bullies, threatens others
	Loses needed items often		Starts fights
	Easily distracted		Used a weapon
	Forgetful		Physically cruel to people/animals
	Fidgets, squirms		Forcibly stolen from victim
	Leaves set when required to sit		ANXIETY/WORRY
	On the go seems driven		Intense fears or phobias
	Runs, climbs or excessively restless		Worries something terrible will happen to self/adults
	Talks excessively		Refuses/reluctant to go somewhere because of fear
	Interrupts others conversations or activity		Frequent fear to go to sleep without someone
	Problems waiting for a turn		Avoids being alone, clingy
	Bizarre behaviors		Nightmares about separation
	MOOD		Physical complaints about the time of separation
	No symptoms for more than two months during past year		Worries about parent(s) leaving
	Weight changes, appetite changes		Obsessive or compulsive behavior or rigid rituals
	Energy level changes		Extreme fear of new places or situations
	Sleep disturbances		**OPPOSITIONAL BEHAVIORS**
	Concentration problems		Touchy easily annoyed

	Crying spells		Argues
	Loss of interest, pleasure in once enjoyable activities		Defiant
	Hopeless feelings		Tantrums
	Guilty feelings		Bothers others deliberately
	Isolates self		Spiteful/mean
	Low self esteem		Blames others for own mistakes
	Gives things away		OTHERS:
	Wishes to be dead/talks of death		
	Injuries self		
	Thinks about death/violence often		
	Rage outburst		
	Thinks she/he is smartest/best person in the world		

MY STRENTHS:

In school settings:

In social settings:

Special Interests/Hobbies: