



Lighthouse Family Counseling

Safety, Hope, and Guidance

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ADOLESCENT INFORMATION FORM

Name _____ Date of 1st Appointment _____ Therapist _____

Date of Birth _____ Age _____ Gender: Male _____ Female _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Current medications being taken:

1) _____ Dosage/Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Circle One) YES NO

If yes, please explain: _____

What was the last year of school you completed? _____ What school are you currently attending? _____

Who is in your current support network? (friends, relatives, other adults): _____

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

With whom do you live? Mother _____ Father _____ Stepmother _____ Stepfather _____ Guardian _____ Grandparent _____

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your relationship with your mother:

Currently: _____

In the past: _____

Describe your relationship with your father:

Currently: _____

In the past: _____

Describe your relationship with your stepmother:

Describe your relationship with your stepfather:

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse: _____

Sexual/physical/emotional abuse: _____

MENTAL STATUS

Please check any of the following that describe how you believe you feel:

sad anxious depressed frightened guilty angry ashamed aggressive resentful
 worthless tearful irritable confused extreme ups/downs jealous hopeless helpless
 annoyed

Describe any other feelings you have had: _____

Please check any of the following risk-taking behaviors you have engaged in:

street racing gang involvement skip school dropped out dangerous dieting cutting stealing
 unprotected sex running away bullying others fire starting hurt animals restrict or restricted food intake
 over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

beer wine hard liquor pot cocaine heroin Ecstasy speed over the counter drugs
 prescription drugs ice Triple C's dones quad bars Other: _____

Have you had any change in sleeping habits? (Circle One) YES NO

Describe: _____

Have you had any change in eating habits? (Circle One) YES NO

Describe: _____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List any current problems you are having in daily psychological, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members): _____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES NO

Describe: _____

How much time do you spend online or gaming? _____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!