Kate Westhoven, PsyD

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ADOLESCENT CLIENT INFORMATION SHEET

Today's Date: _____

Client's name: _____ **Date of Birth:** _____

Person completing this form: _____

Mother's name: _____

Father's name: _____

Client's custodian/guardian: _____

Other adults living in the home: _____

Client's Address: _____

Parent's/Guardian's address (if different from above): _____
Permission to send regular mail, which may include Protected Health Information (PHI) Yes ___ No* ___
*if this is declined, mail will be sent Certified Return Receipt

Email Address Parents/Guardians: _____

Email Address Child: _____
Permission to use this email address to send information which may include PHI Yes ____ No ___

Preferred Phone: _____ OK to leave message? Yes __ No __
Alternative Phone: _____ OK to leave message? Yes _ No ___

Emergency Contact: _____ **Phone:** _____
Address: _____

I give Kate Westhoven, PsyD permission to contact my Emergency Contact person in an emergency.

_____
Signature of Client Date

_____
Signature of Parent/Guardian Date

_____
Signature of Parent/Guardian Date

ADOLESCENT CLIENT, PLEASE COMPLETE THIS PAGE
PARENT/GUARDIAN, PLEASE COMPLETE PAGES 3 - 5

Please briefly describe your reasons for seeking therapy at this time: _____

_____

_____

_____

Current psychiatrist (or doctor who prescribes psychiatric medications: _____

Current psychiatric medications: _____

Are you currently experiencing any thoughts of suicide? _____

Are you currently experiencing any thoughts of homicide? _____

Please check all of the following that are concerns and CIRCLE those which are most concerning (THIS IS TO BE COMPLETED BY THE CLIENT):

___	Academic Issues	___	Aggressive Behavior	___	Alcohol
___	Anger	___	Anxiety	___	Attention
___	Body Image	___	Bullying	___	Concentration
___	Diet Issues	___	Divorce/Separation	___	Drug Use
___	Emotional Abuse	___	Employment/Career	___	Failure
___	Family Relationships	___	Fatigue	___	Fears
___	Feelings of Worthlessness	___	Financial Problems	___	Food Concerns
___	Friendships	___	Gender Identity	___	Grief
___	Guilt	___	Hallucinations	___	Health/Medical Concerns
___	High Risk Behavior	___	Impulsivity	___	Isolation
___	Legal	___	Loneliness	___	Memory
___	Mood Swings	___	Motivation	___	Mourning
___	Neglect	___	Nervousness	___	Nightmares
___	Panic Attacks	___	Parenting Concerns	___	Phobia(s)
___	Physical Abuse	___	Pornography	___	Prescription Drug use
___	Procrastination	___	Relationships	___	Repeated behaviors
___	Repeated troubling thoughts	___	Sadness	___	Self Injury
___	Sexual Abuse	___	Sexual Assault	___	Sexual Concerns
___	Sexual Orientation	___	Sleep	___	Stress
___	Verbal Abuse	___	Violent Behavior	___	Violent Thoughts
___	Weight Issues	___	Worry	___	Other:_____

TO BE COMPLETED BY PARENTS/GUARDIANS
CHECKLIST OF CHARACTERISTICS THAT DESCRIBE ADOLESCENT:

□Abuse—physical, sexual, emotional, cruelty to animals
□ Affectionate
□ Alcohol use
□ Anger, aggressive, hostility, arguing, irritability
□ Anxiety, nervousness
□ Attention, concentration, distractibility
□ Cheats
□ Concern for others
□ Conflict with parents
□ Confusion
□ Compulsions
□ Cries easily, feelings are easily hurt
□ Decision making, indecision, mixed feelings, putting off decisions
□ Delusions (false ideas)
□ Dependence
□ Depression, low mood, sadness, crying
□ Developmental delays
□ Drug use—prescription medications, over-the-counter medications, street drugs
□Eating concerns—overeating, under eating, appetite, vomiting
□Extracurricular activities interfere with academics
□ Failure in school
□ Fatigue, tiredness, low energy
□ Fears, phobias
□ Fire setting
□ Friendly, outgoing, social
□ Gambling
□ Grieving, mourning, deaths, losses
□ Guilt
□ Headaches, other kinds of physical pain
□ Health, illness, medical concerns, physical problems
□ Housework/chores—quality, schedules, sharing duties
□ Inferiority feelings
□ Interpersonal conflicts
□ Impulsiveness, loss of control, outbursts
□ Irresponsibility
□ Judgment problems, risk taking
□ Learning disability
□ Loneliness
□Low frustration tolerance
□ Memory problems
□ Mood swings
□ Motivation
□ Nail biting
□ Nervousness, tension

□ Obsessions, compulsions (thoughts or actions that repeat themselves)
□ Pain, chronic
□ Panic or anxiety attacks
□Relationships (family)
□Relationship (friends)
□ Responsible
□ Runs away
□ School problems
□ Sad, unhappy
□ Self-harming behaviors-biting, hitting, cutting self
□ Self-neglect, poor self-care
□ Sexual issues, dysfunctions, conflicts, desire differences
□ Shyness, oversensitivity to criticism
□ Sleep Problems-too much, too little, insomnia, nightmares
□ Smoking and tobacco use
□ Spiritual, religious, moral, ethical issues
□ Stress, relaxation, stress management, stress disorders, tension
□ Suspiciousness, distrust
□ Suicidal thoughts or attempts
□ Tics-involuntary rapid movements, noises, or word productions
□ Thought disorganization and confusion
□ Teased or teases others
□ Truancy
□ Weight and diet issues
□ Withdrawal, isolating
□ Other:_____

Please look back over the concerns you have checked off and choose the one(s) that are most concerning to you.

_____

Please list all past psychological treatment, including psychotherapy, psychiatry, suicidal thoughts/attempt, homicidal thoughts/attempts, hospitalizations: _____

_____

_____

_____

_____

_____

_____

_____

Please list medical history (hospitalizations, chronic conditions, accidents, head injuries, convulsion/seizures, major illnesses, medications, allergies, surgeries):_____

_____

_____

_____

_____

_____

_____

_____

Signature of Parent/Guardian **Date**

_____

Signature of Parent/Guardian **Date**