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Part 1 – To be completed by the parent or guardian of Client (Adolescent)

Today's Date: ____/____/____ How were you referred? _____

CLIENT (Adolescent) INFORMATION

Client name: _____ Date of Birth: ____/____/____ Age: _____ Grade Level: ____

School Name:_____ School Counselor Name (if any) _____

Legal Guardian(s) _____ Which Guardian do you live with: _____

Phone: _____ Email: _____ Religious Affiliation: _____

PARENT/GUARDIAN INFORMATION

Mother's Name: _____ Father's Name:_____

Age: ____ Employer/Title_____ Age: ____ Employer/Title_____

Religious Affiliation: _____ Religious Affiliation: _____

Marital Status: _____ Marital Status _____

Address: (street/city/state/zip) _____ Address/City/State Zip : _____

_____ _____

Phone: _____ Email: _____ Phone: _____ Email: _____

FAMILY COMPOSITION

Who currently resides in the same home(s) as the Client?

NAME	Age	Relationship	NAME	Age	Relationship
1) _____	_____	_____	4) _____	_____	_____
2) _____	_____	_____	5) _____	_____	_____
3) _____	_____	_____	6) _____	_____	_____

CLIENT MEDICAL AND PERSONAL INFORMATION

Has Client had counseling before: Y N Inside or Outside of School?: _____ Dates To / From: _____

Counselor Name (s): _____ Outcome and diagnosis: _____

Date of Last Medical Exam: ____/____/____ Please rate Client's health: Excellent Good Average Poor

Does Client have serious medical conditions? Yes ____ No ____ (If yes, please describe)

Is Client on OTC or prescription medications? Yes ____ No ____ (Name, Dose, Purpose)?

Does Client have any addictions? Yes ____ No ____ Uncertain ____ (describe)

Describe any noticeable changes in (Hygiene, Eating, Sleeping, Social Interactions)?

Has Client experienced or witnessed Traumatic Events (physical, emotional, sexual, other.) Yes ____ No ____ Uncertain ____

Has Client ever been arrested? Yes ____ No ____

Has Client engaged in or attempted physical violence toward another person (or animal)? Yes ____ No ____

Has Client engaged in self-injurious behavior, suicidal attempts or expressions? Yes ____ No ____ Uncertain ____ (describe)

BASIC INFORMATION (Briefly answer the following questions:)

What concern(s) have caused you to bring Client to counseling at this time?

How would Client would describe the Concern(s) for which counseling is being sought?

What has been done to address concern(s) up to this present time?

Has anyone in the family experienced similar problems? If yes, please explain:

What is your assessment of Client's personality? (Strengths, Self-improvement opportunities etc

How does the Client handle stress?

Describe Parenting style(s) to which Client is exposed?

Describe current family dynamics (relationship <u>strengths/challenges</u> among family members)?

What are your hopes/expectations for Client during counseling?

Is there any other information you feel I should know? If yes, please explain:

Part 2 – to be completed by the Client

Have you ever visited a Counselor before? (If Yes, did you like or dislike the experience and why?)

Why do you think your Parent/Guardian suggested you visit with a Counselor?

Describe the Best Times of your Life – when you were the happiest?

What have you done that you are Most Proud of?

What are your personal Strengths that help you cope when times are hard?

Who do you consider as part of your supportive network (i.e, friends, family members, others)?

What things/hobbies do you enjoy?

What do you like about yourself?

What do other people like about you?

Describe the Worst Time(s) in your life and who helped you through it?

Describe any worries or fears about anything in your life that has bothered you recently or for a long time

Have you been <u>less</u> interested in most things, or less able to enjoy the things you used to? Yes ____ No____ (If Yes, for how long?)

Have you felt sad, low or depressed most of the time? Yes ____ No____ (If yes, for how long?)

Do you ever feel anxious? Yes ____ No____ If Yes, describe when you feel this way? (Examples:: Feeling like people are looking at you, Talking or eating in front of others; Standing in crowds/groups; Traveling in cars, planes, buses; Worry about things happening to you or others):

Check any if they describe how you have been feeling lately: Sad ___ Isolated ___ Angry ___ Anxious ___ Frightened ___ Confused ___ Disconnected ___ Hopeless ___ Helpless ___ Worthless ___ Numb ___

Do you Exercise? Yes ____ No ____ (If yes, please describe)

Notice any changes in your Sleep Habits? Yes ____ No ____ (If yes, please describe)

Notice any changes in your Eating Habits? Yes ____ No ____ (If yes, please describe)

Do you smoke? Yes ____ No ____

Do you drink Alcohol? Yes ____ No ____(If yes, what type, how much, how often, when was last drink consumed?)

Do you use recreational drugs? Yes ____ No ____(If yes, what type, how much, how often, when last used?)

Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that resulted in actual/threatened death or serious injury to you or someone else? Yes ____ No ____ (If yes, please describe):

Have you re-experienced the traumatic event in a distressing way in the past month? Yes ____ No ____ (If yes, check any of the following that apply): (Dreams/Nightmares ____; Intense recollections ____; Flashbacks ____; Physical reactions ____)

Have you ever been hospitalized for medical or psychiatric reasons? ____(If yes, please describe)

Have you ever engaged in self-injurious behavior? Yes ____ No____ (If yes, briefly describe)

Have you ever thought about suicide? Yes ____ No____ If Yes, what would stop you from doing this?

Have you ever thought about hurting or killing someone else? Yes ____ No____ If Yes, what would stop you from doing this?

If anything in your life could be different, what would you want to change?

List three (or more) things that are important to you:

1)

2)

3)

Complete these sentences:

1) I am
2) Others are
3) My world is