New Adolescent Client Information Form

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Today's Date: _______________

About You:

Name:______________________________________ Date of Birth:__________________________

Address:____

Cell Phone: ___________________________ Email: ______________________________________

Your Family:

Name(s) of those living in your household ____

____________________________________ ____________________________________ ___________________

Emergency Contact (consent to contact in case of emergency):

Name:_________________________ Relationship to Client(s): _____________________________

Home Telephone: __________________________ Cell: ___________________________________

Description of Presenting Issues:

What brings you to therapy at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What do you think you need help with the most right now?

What are your goals for therapy?

Have you seen a mental health professional before? If so, please specify dates, the reason for therapy, and your experience. What was your diagnosis, if any?

Social and School Functioning:

Are you currently in school? If yes, what school and grade are you in?

If you are in school, what is it like for you?

During the past school year, about how many days were you absent when you were supposed to be in school?

Have you ever been suspended or expelled from school? If yes, please share additional details.

Family History:

Please describe your relationship with your parents/family.

If you are in a relationship, please describe the nature of the relationship and months or years together.

Who do you know that you would consider your closest sources of support or your "inner circle" (e.g., grandparent, aunt, uncle, friend, cousin, teacher, etc.)?

Medical History:

Primary Care Physician___________________________ Telephone: ______________________

Please list medications you are currently taking:

Name & dosage: _________________________ Prescribed for: __________________________

Any side effects? _________________________ Helpful? ______________________________

Name & dosage: _________________________ Prescribed for: __________________________

Any side effects? ___________________________ Helpful?______________________________

Do you have any allergies?

Do you have any significant health concerns?

Describe any physical pain/issues which may be related to reasons you are seeking therapy:

Mental Health History:

Do you have difficulty falling asleep? ___________ How many hours do you average each night? _____

Do you have difficulty maintaining a healthy weight?

Do you drink alcohol? If yes, please describe the type, amount and frequency.

Do you use recreational drugs? If yes, please describe the type, amount and frequency.

Do you currently, or have you ever had suicidal thoughts? Please describe.

Have you ever attempted suicide?

Do you ever have thoughts or urges to harm others?

Have you ever been hospitalized for a psychiatric issue?

Is there a history of mental illness in your family? Please list.

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Please check any of the following you have experienced in the past six months:

Increased appetite
Decreased appetite
Trouble concentrating
Difficulty sleeping
Excessive sleep
Low motivation
Isolation from others
Fatigue/low energy
Low self-esteem
Depressed mood
Tearful or crying spells
Anxiety
Panic
Hopelessness
Self-Harming Behaviors
Suicidal Thoughts
Homicidal Thoughts
Physical Aggression Towards Others
Hearing Voices That Others Do Not
Seeing Things That Others Do Not
Binging/Purging
Restricted Eating

Is there anything else you would like me to know?

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