

Anne MacDavid, MFT, Psychotherapy Associates
CLIENT HISTORY FORM – Adolescent/Teen (ages 12 -17)

*****THIS FORM TO BE FILLED OUT BY ADOLESCENT AND GIVEN DIRECTLY TO THERAPIST**

This form will assist your therapist in knowing about you and will be kept confidential.

Date: _____

Client Name: _____ Birth date: _____ Age: _____

Grade _____ Social Security # _____

PRESENTING PROBLEM

Describe the problems you are having and when they began: _____

What has contributed to this difficulty?

MEDICAL HISTORY

List allergies, serious illnesses, surgeries, injuries, hospitalizations: _____

List both prescription and over-the-counter medications presently used for physical conditions: _____

My over-all general health is: ___Excellent ___Good ___Fair ___Poor

What physical illnesses run in your family?

What is the name of your Doctor/Pediatrician? _____

EDUCATIONAL HISTORY

What is the highest grade you have completed? _____

Do you have any problems in school? _____

Have you ever repeated or skipped a grade? Which one? _____

Have you ever dropped out, been expelled, or been suspended? Which one? What happened? _____

How has your attendance been? _____Excellent _____Good _____Poor

What are your grades like? _____ Have they changed a lot? _____

Do you have learning difficulties or attend special classes? _____

Have you ever had psychological testing? _____

What are your extra-curricular activities? _____

Do You Work? ___Yes, ___NO, **If Yes,** Where do you work and what do you do?

CFGF Adolescent/Teen Information con't

LEGAL HISTORY (in regards to child or any family member)

Have you ever been involved with the legal system? (criminal, divorce, custody, civil, etc.) ___ Yes ___ No

If so, in what way? _____

Are you currently involved with the legal system? (criminal, divorce, custody, civil, etc.) ___ Yes ___ No

If so, in what way? _____

Do you have any criminal or civil cases pending? ___ Yes ___ No

Do you currently have a probation/parole officer? ___ Yes ___ No, If yes, who? _____

Do you anticipate any involvement with the legal system in the future? _____

TREATMENT HISTORY

Have you been in counseling before? ___ Yes ___ No If Yes, with whom? _____

What was the primary issue? _____

When? _____

For how long? _____

What was the outcome? _____

Have you ever been hospitalized for emotional problems or for alcohol/drug treatment? ___ Yes ___ No

If yes, when? _____

Where? _____ What

was the outcome? _____

What medications have you taken in the past for emotional or mental problems? _____

What medications are you currently taking for emotional or mental problems? _____

Is there a history of mental illness in your family? ___ Yes ___ No If yes, please list family members

SOCIAL HISTORY

What are your major strengths? _____

What are your major weaknesses? _____

From whom do you get emotional support? _____

Do you have friends? _____

How do you get along with those friends? _____

Has there been a change in your circle of friends lately? _____

Do your friends tend to get into trouble? _____

____ Build (light, average, heavy)
 ____ Breast development (female)
 ____ genital hair

____ Voice change (male)
 ____ Beard (male)
 ____ Acne

SEXUAL HISTORY

Sex Education: ____ Home; ____ School; ____ Friends
 Do you masturbate? ____ Are you a virgin? ____
 Are you currently sexually active? ____
 Single Partner ____ Multiple Partners ____ Same Sex Partner ____ Both Sex Partners
 ____ Do you use Condoms? ____ Do you use Birth Control? ____
 Have you ever had a STD (Sexually Transmitted Disease)? ____ Yes ____ No If so
 what? ____
 Have you ever been sexually abused? ____ Yes ____ No If yes by whom and for what length of
 time? _____

Has anyone ever touched you or talked to you sexually in a way that made you uncomfortable?

CFGC Adolescent/Teen Information cont.

CONCERNS

For you or any of the above relationships (household, brothers/sisters, partners), have you or any of those persons
 ever experienced any of the following problems:

Concern	Person(s) Who Experienced This
Mental Illness	_____
Depression	_____
Neglect	_____
Sexual Dysfunction	_____
Financial Difficulty	_____
Emotional Abuse	_____
Physical Abuse	_____
Sexual Abuse	_____
Alcohol Abuse	_____
Drug Abuse	_____
Other: _____	_____

POSSIBLE ISSUES

SUBSTANCE ABUSE

Do you use drugs? ____ No ____ Yes Regularly? Occasionally? How does your usage affect your
 life?) _____

What drugs have you taken:

- ____ Depressants: Alcohol, Tranquilizers, Sleeping Pills, Inhalants
- ____ Stimulants: Cocaine, Crack, Crank, Speed, Diet Pills
- ____ Stimulants: Caffeine, Nicotine
- ____ Narcotics: Heroin, Codeine, Morphine
- ____ Hallucinogens: LSD/Acid, PCP, Peyote, Shrooms
- ____ Cannabis: Marijuana
- ____ Other: _____

When did you first use? _____ When did you last
 use? _____

SUICIDE/HOMICIDE

Have you ever had or do you have:

	Past	Now
Thoughts of hurting yourself?	_____	_____
Thoughts of committing suicide?	_____	_____
Plans to commit suicide?	_____	_____
Attempts to commit suicide?	_____	_____
Threats to commit suicide?	_____	_____
Thoughts of harming someone?	_____	_____
Plans to harm someone?	_____	_____

Attempts to harm someone?
Threats to harm someone?
Actually harmed someone?

_____	_____
_____	_____
_____	_____

DEPRESSION

Has you ever or do you now have:

Past Now

Inability to sleep or sleeping longer?
Increased or decreased appetite?
Tearfulness or feelings of despair?
Lack of energy or feelings of fatigue?
Preoccupation with life events?
Decreased contact with others?
Feelings of depression?
Decreased interest in pleasurable activities

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Is there anything else that may be helpful for your counselor to know that we have not asked? _____