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ADOLESCENT INFORMATION FORM

This document asks lots of questions but is very helpful to your therapist. This is typically completed by the parent(s)/or guardian in consultation with the teen. For privacy and more honest answers regarding *feelings*, *drug use* or *risky behaviors*, the parent/guardian may ask the teen to finish that portion of the form after other questions have been supplied or the youth can respond to those questions when alone with the therapist.

If parents are divorced, please bring a copy of the decree pertaining to healthcare decision authority. This is required by state regulation with no exceptions or the youth cannot be seen.

Legal Name_____ Preferred Name: _____Date of 1st Appointment_____

Date of Birth _____ Age _____ Gender: Male_____ Female_____ Trans_____

Name of current school you attend:_____

Current Grade Level_____ Typical grades or average of report card:_____

Mailing Address where child primarily lives: Physical Address if different than mailing address:

_____ _____

_____ _____

_____ _____

Parent/Guardian Contact information

Who has legal custody of this minor? _____ Relationship _____

Does minor live with this custodial parent/guardian? Yes No

If not, with whom does minor client live?_____

Is custody shared, and if so, with whom? (Name and Relationship)_____

Address if different than above: _____

_____

_____

Best Contact Phone Number for this person:_____

The following applies to the Custodial Parent: Preferred Contact And Privacy Preferences

Voice: Home Phone (____)_____ [] Check which is preferred method(s)

Cell Phone (____)_____ []

Work Phone (____)_____ []

Email _____[]

May CCIA contact you via: Email? Yes No

Voice mail at: Home Yes No

Cell Yes No

Work Yes No

Should CCIA need to mail something to you, may we do so via your home address? Yes No

If you prefer an Alternate Address, please list:

If youth/child has their own cell phone and Email address please list

Email: _____

Cell phone: _____

Who will be bringing the child/youth to counseling? (This person must remain in the building.)

Name and Relationship:

Cell phone number:_____

How did you learn of CCIA or Dr. Kindley? _____

If it was an ad, where did you see/hear the ad?

The following pertains to the Youth Client:

If you are employed, please tell where and what it is that you do.

Business Name/Job and location:

How long have you been with this employer/business?_____

II. MEDICAL HISTORY

Name of Primary Care Physician:_____ Date of last medical evaluation:_____

Name of Psychiatrist (if seen by one)_____Date of last appointment:_____

Current medications being taken: Approximate

1)_____ Dosage/Freq _____Start Date_____Purpose_____

2)_____ Dosage/Freq _____Start Date_____Purpose_____

3)_____ Dosage/Freq _____Start Date_____Purpose_____

4)_____ Dosage/Freq _____Start Date_____Purpose_____

5)_____ Dosage/Freq _____Start Date_____Purpose_____

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, addictions (including nicotine), or other emotional difficulties? Please list:_____

_____

_____

III. SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? YES NO

If yes, please explain:_____

Did you ever skip or repeat a grade?_____

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

_____

Please check all information which applies to your biological parents:

MOTHER		FATHER	
	____ living		____ living
	____ deceased		____ deceased
	____ married		____ married
	____ divorced		____ divorced
	____ remarried ____# of times		____ remarried ____# of times
	____ status unknown		____ status unknown
	____ I've never known my biological mother		____ I've never known my biological father

____ I was legally adopted _____I live with a foster family

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:_____

IV. PSYCHOLOGICAL HEALTH and BEHAVIORAL STATUS

Is the youth client currently seeing, or have they ever seen a psychiatrist, therapist or counselor? If so, please give the person's name, approximate months seen, and primary purpose of visits.

Has anyone else in the family ever seen a psychiatrist, therapist or counselor?

Check all that apply to you:
__Learning Disability __Attention Deficit Issues __Communication or Processing Delays or Issues
__Hyperactive Issues __Legal Issues __Nightmares or night terrors __Phobias (specific intense fears)
__Drug use/concerns __Compulsive or Obsessive Behavior __Discipline issues __Excessive anger/tantrums
__Depressed mood __Up & Down moods that swing often or excessively __Anxiety __Academic/school issues
__Few friends
__(list other concern(s)_____)

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 ___sexting ___pornography use

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 ____Triple C's (Coricidin Cough & Cold) ____dones (Methadone) ____quad bars (Xanax)

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/situation? (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/situation? (Circle One) YES NO

If yes, please explain:_____

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

If yes, please explain:_____

V. 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?_____

Do you have a cell phone that you use? YES NO Do you frequent chat rooms? YES NO

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 (WHY you are here / WHAT you wish to accomplish):

_____

_____

_____

_____

THANK YOU!