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Teen Personal History:

Intake Date;_____ *Completion Date:*_____*Termination Date:*_____

Name of Client:_____Birthdate: _____

Address:_____

Phone:_____City and State:_____ZIP Code:_____

Clients Phone: _____E-Mail:_____

Family History:

Parent Name: _____ Birthdate:_____

Single: _____ Married:_____(1st/ 2nd/ 3rd):_____

Spouse's Name:_____Spouse's Birthdate:_____

Address:_____City:_____State:_____Zip:_____

Separated:_____Date of Separation:_____

Divorced:_____ (1st/ 2nd/ 3rd) Date of Divorce:_____

Living with Significant Other/Roommate:_____

Employer:_____Occupation:_____

Siblings' Names:_____ Ages: _____

Siblings' Name:_____ Ages: _____

Religious Preference/Affiliation_____

Medical History/Insurance Information:

Personal Physician:_____Phone:_____

Address: _____City and State:_____

Current medical conditions:_____

Current Medications and Dosages: _____

Date of last Medical Exam:_____

Insurance Policy Holder:_____Date of Birth:_____

Reason for attending therapy:

What brings you to therapy now?_____

_____

_____

What else would you like me to know? _____

_____

What would you like to achieve from therapy?_____

Who referred you to me?_____

Child's School History:

Current School District: _____ Grade: _____

School Name: _____ Phone #: _____

Review history of school functioning (Gifted, Behavioral Issues, Continuation, Homeschooling etc.):_____

_____

Currently has… SST: ____ 504 Plan___ IEP_____

Teacher/Counselor/EP Coordinator: _____

Emotional Disturbed (ED): ____ Specific Learning Disability: _____

Regular Education: _____ Pull out to Resource Room: _____

Special Education: _____ Other: _____

What school interventions if any has been used to address the problem(s): _____

_____

_____

Adolescent's symptoms, problems, or complaints:

Please check, which areas are you concerned about:

Isolates/withdraws: ____

Irritability: _____

Panic Attacks: _____

Hyperactive: _____

Nightmares: _____

Mood Swings: _____

Separation Anxiety: ____

Tearfulness: _____

Racing thoughts: _____

Hopelessness: _____

Cries Easily: _____

Inattentiveness: _____

Frequent Fighting: _____

Generalized anxiety: _____

Decrease in energy: _____

Frequent outbursts: _____

Appetite changes: _____

Aggression toward others: _____

Worries/fears: _____

Sadness: _____

Problems Concentrating: _____

Stomachaches or Headaches: _____

Sleep Disturbances: _____

Loss of interest in activities: _____

Memory Issues: _____

Defiant Behaviors: ____

Weight Change: _____

Provokes others: _____

Cutting: _____

Truancy: _____

Anger issues: _____

Sexually acting out: ___

Bullies others: _____

Little or no friends: ____

Poor social skills: _____

Binging/Purging: _____

Steals: _____