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TEEN PATIENT INFORMATION

First Name: _____**MI**_____ **Last Name**: _____

Address: _____ City: _____St.____Zip_____

Home Phone:_____ Wk Phone: _____ Cell: _____
Birth Date:_____/_____/_____ **Age**:_____ **E Mail**:_____
Highest Educational Level:_____

State the problem or concern for which you are seeking counseling:

What have you done to try to solve this problem?

Is there any special assistance you are seeking?

Previous therapists? Yes ○ No ○ When?_____ Was it helpful? _____
Are there current suicidal thoughts? No Have you attempted Suicide? No
Have you had difficulty with anger? No Been violent? No Injured someone? No

Have you ever had school, relationship, health, or legal problems due to your use of alcohol or drugs? Yes

Date you last drank alcohol. _____ How much typically?_____ Do you smoke? Yes How much _____

Date you last used drug(s) and type of drug used: _____
How much coffee, colas, or teas do you drink per day? _____

Family history of mental health or substance abuse problems?_____

Check any that have happened: Emotional Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐

Have you had a head injury with loss of consciousness or caused you to see a doctor? Yes

Have you had any of the following:

Learning disabilities ☐ Hyperactivity ☐ Disciplinary problems ☐

Menstrual problems ☐ Possible PMS ☐ Premenopausal/Menopausal ☐

Any type of sleep problems: Falling asleep ☐ Staying asleep ☐ Early awakening ☐ Difficulty awakening ☐

Any appetite changes Yes Weight changes Yes Current weight: _____ lbs. Height: _____

Describe your worst nutritional habits _____

Legal Problems? Arrests? _____

Exercise? Frequency of physical activity? _____

Hobbies / Interests? _____

Describe your religious or spiritual beliefs _____

Check any of the following concerns - Make any additional comments

Shyness ☐	Panic ☐	Attention Deficit ☐	Phobias ☐
Health ☐	Controlling ☐	Over-Weight ☐	Stress ☐
Inferiority ☐	Depression ☐	Bullying ☐	Obsessions ☐
Self-Injury ☐	Concentration ☐	Guilt ☐	Insecurity ☐
Memory Problems ☐	Self-Esteem ☐	Eating Disorder ☐	Attitude ☐
Ambition ☐	Confusion ☐	Spending ☐	
Work ☐	Perfectionism ☐	Drug Use ☐	
Anger ☐	Relationship ☐	Gambling ☐	
Jealousy ☐	Mood Swings ☐	Self Critical ☐	
Nervousness ☐	Career ☐	Compulsions ☐	
Making Decisions ☐	Physical Pain ☐	Worry ☐	

Comments:

Describe your health at present

List any medical problems you may have

List any operations

List any allergies you have, including allergies to medications

List any recently discontinued medications, psychiatric medications

If there is a need to call, may we leave a message on voice mail or with a family member? Yes

_____ _____

PATIENT SIGNATURE DATE