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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?_____

_____

Any previous therapists? _____When?_____ Was it helpful?_____

Are there current suicidal thoughts? ____YES ____ NO; Attempted suicide? ____YES ____ NO

Have you ever had difficulty with your anger? ___ YES ___ NO, been violent? ___ YES ___ NO
or injured someone?___ YES ___ NO

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

Date you last drank alcohol. _____How much typically?_____ Do you smoke? ___ How much_____

Date you last used drug(s) and type of drug used: _____
(Fill out back side of this sheet)

How much coffee, colas, or teas do you drink per day? _____

Family history of mental health or substance abuse problems?_____

Circle 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 _____ NO

Have you had _____learning disabilities, _____hyperactivity or _____disciplinary problems?

Menstrual problems? ____Possible PMS?____

Any type of sleep problems?_____

Any appetite changes? _____or weight changes?_____

Legal Problems? Arrests? _____

Exercise or physical activities?_____

Hobbies / Interests?_____

Describe your religious or spiritual beliefs_____

Circle any of the Following:	*Comments*		*Comments*
Attention Deficit		Guilt	
Over-Weight		Eating Disorder	
Finances		Spending	
Alcohol		Drug use	
Low energy		Gambling	
Self Critical		Critical	
Sexual Problems		Marriage	
Anxiety		Relaxation	
Compulsions		Phobias	
Fears		Worry	
Stress		Obsessions	
Insecurity		Parenting	
Shyness		Health	
Bullying			
Inferiority		Self Injury	
Memory Problems		Ambition	
Work		Anger	

Jealousy	Panic
Controlling	Depression
Concentration	Self Esteem
Confusion	Perfectionism
Relationship	Mood Swings
Career	Nervousness
Making Decisions	Physical pain

List any medical problems you have: _____
_____

List any operations you have had: _____
_____

List medications you are taking	**Dosage**	**Number of times per day**	**Prescribed since when?**

List any recently discontinued medications_____
_____

List any allergies you have, including allergies to medications: _____
_____

If there is a need to call, may we leave a message on voice mail or with a family member? ___ YES ___ NO

_____ _____

PATIENT SIGNATURE DATE