TEXAS COUNSELING
Individual, Couples, Family
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ADOLESCENT INFORMATION FORM

Name _____ Date of 1st Appointment _____

Date of Birth _____ Age _____ Gender: _____

MEDICAL HISTORY

Name of Primary Care Physician:

_____

Medications taken currently:

1)		Dosage/Freq	Start Date	Purpose
2)		Dosage/Freq	Start Date	Purpose
3)		Dosage/Freq	Start Date	Purpose
4)		Dosage/Freq	Start Date	Purpose

Prescribed by:

_____

Have you ever been hospitalized for medical or psychiatric reasons? (Check one) ☐ YES ☐ NO

Hospital	Mo/Yr	Reason

Describe any important medical history, chronic ailments, or other health problems you experience or experienced in the Past:

_____

_____

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, or other emotional difficulties? Please list:

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Check One) ☐ YES ☐ NO

If yes, please explain:

What was the last year of school you completed?

Name of school you are currently attending:

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

Please check **all** information which applies to your biological parents:

MOTHER	☐ living	FATHER	☐ living
	☐ deceased		☐ deceased
	☐ married		☐ married
	☐ divorced		☐ divorced
	☐ remarried ____ # of times		☐ remarried ____ # of times

With whom do you live? ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Grandparent ☐ Guardian

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:

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 that you experience:

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 food intake ☐ binging ☐ over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

☐ beer ☐ wine ☐ hard liquor ☐ marijuana
☐ heroin/opiates ☐ Ecstasy/MDMA ☐ meth ☐ over the counter drugs
☐ prescription drugs ☐ cough syrup/DXM ☐ Xanax ☐ cocaine
☐ psychadellics ☐ inhalents ☐ nicotine
☐ Other:

Have you had any change in sleeping habits? (Check One) ☐ YES ☐ NO

Describe:

Have you had any change in eating habits? (Check One) ☐ YES ☐ NO

Describe:

Have you ever **considered suicide** in connection to your **current** problem? (Check One) ☐ YES ☐ NO

If so, please give a brief description with dates:

Have you ever **considered suicide** in the **past**? (Check One) ☐ YES ☐ NO

If so, please give a brief description with dates:

Have you **attempted suicide recently** or in the **past**? (Check 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? (Check One) ☐ YES ☐ NO

If yes, please explain:

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

If yes, please explain:

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? (Check One) ☐ YES ☐ NO

Describe:

How much time do you spend online or gaming?

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:

1.
2.
3.
4.
5.

THANK YOU!