Child & Family Guidance Center of Texoma

CLIENT HISTORY FORM – Adolescent/Teen (ages 12 -17)

*****THIS FORM TO BE FILLED OUT BY ADOLESCENT AND GIVEN DIRECTLY TO THERAPIST**

This form will assist your therapist in knowing about you and will be kept confidential.

Date:____________________

Client Name:____ Birth date:_______________ Age:_______

Grade__________________________Social Security #____

PRESENTING PROBLEM

Describe the problems you are having and when they began:____

____

____

What has contributed to this difficulty?

____

____

MEDICAL HISTORY

List allergies, serious illnesses, surgeries, injuries, hospitalizations:____

____

____

List both prescription and over-the-counter medications presently used for physical conditions:____

____

My over-all general health is: ___Excellent ___Good ___Fair ___Poor

What physical illnesses run in your family?

What is the name of your Doctor/Pediatrician?____

EDUCATIONAL HISTORY

What is the highest grade you have completed?____________________________________

Do you have any problems in school?____

Have you ever repeated or skipped a grade? Which one?____

Have you ever dropped out, been expelled, or been suspended? Which one? What happened?____
_

How has your attendance been? __________Excellent _____Good ____Poor

What are your grades like?_______________________ Have they changed a lot?________________________________

Do you have learning difficulties or attend special classes?____

Have you ever had psychological testing?____

What are your extra-curricular

activities?____

Do You Work? _____Yes, _____NO, If Yes, Where do you work and what do you do?
____

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LEGAL HISTORY (in regards to child or any family member)
Have you ever been involved with the legal system? (criminal, divorce, custody, civil, etc.) ___ Yes ____No
If so, in what
way?____

Are you currently involved with the legal system? (criminal, divorce, custody, civil, etc.) ___Yes ___No
If so, in what
way?____

Do you have any criminal or civil cases pending? ___Yes ___No
Do you currently have a probation/parole officer? ___Yes ___No, If yes,
who?___________________________
Do you anticipate any involvement with the legal system in the
future?____

TREATMENT HISTORY
Have you been in counseling before? ___Yes ___ No If Yes, with
whom?______________________________
What was the primary issue?____
When? ______________ For how long?__________ What was the
outcome?_________________________

Have you ever been hospitalized for emotional problems or for alcohol/drug treatment? ___Yes ___ No
If yes, when?__________ Where?_________________________What was the
outcome_________________________

What medications have you taken in the past for emotional or mental
problems?____

What medications are you currently taking for emotional or mental
problems?____

Is there a history of mental illness in your family?___ Yes ___No If yes, please list family members
____

SOCIAL HISTORY
What are your major
strengths?____

What are your major
weaknesses?____

From whom do you get emotional
support?____
Do you have
friends?____
How do you get along with those

friends?____

Has there been a change in your circle of friends lately?____

Do your friends tend to get into trouble?____

Do you belong to a gang?____

Do any of your friends belong to a gang?____

What have been the losses, changes, crises, and transitions in your life?____

Do you have a belief system (cultural, moral, spiritual, religious, etc.) which influences her/his life?____

Is there anything about your lifestyle (or the family's) that would be helpful for your counselor to know?____

____

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FAMILY HISTORY

ABOUT YOUR HOUSEHOLD

Name	Age	Relationship to You	How do you get along

Important people in your life (immediate family/relatives/significant others)

Name	Age	Relationship to You	How do you along

Do you live with your parents? ___Yes ___ No Have you ever lived away from your parents? ___ Yes ___ No

Under what circumstances?____

Do you have any brothers/sisters, step-brothers/sisters, or half-brothers/sisters who do not live with you? ___Yes ___ No

Your experiences while growing up can affect your life. What experiences and events (discipline, favoritism, trauma, affection, lack of attention, etc.) have been important in your life?____

____

Please list your present and past boyfriend(s)/girlfriend(s)

First Name	Time Together	Reason for Ending Relationship

_____________________ ______________ ____________________________________
____

PHYSICAL DEVELOPMENT

Please complete/check the following:

_____Height
_____Weight
_____Build (light, average, heavy)
_____Breast development (female)
_____genital hair
_____Underarm hair
_____Menstruation (female)
_____Voice change (male)
_____Beard (male
_____Acne

SEXUAL HISTORY

Sex Education: _____Home; _____School; _____Friends
Do you masturbate? _________ Are you a virgin? _________
Are you currently sexually active? __________
Single Partner ________ Multiple Partners ________Same Sex Partner ________Both Sex Partners
________Do you use Condoms? ________ Do you use Birth Control? ________
Have you ever had a STD (Sexually Transmitted Disease)? ___ Yes ___ No If so what?_______________________
Have you ever been sexually abused? ___ Yes ___No If yes by whom and for what length of time?____

Has anyone ever touched you or talked to you sexually in a way that made you uncomfortable?
____

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CONCERNS

For you or any of the above relationships (household, brothers/sisters, partners), have you or any of those persons ever experienced any of the following problems:

Concern	Person(s) Who Experienced This
Mental Illness	____
Depression	____
Neglect	____
Sexual Dysfunction	____
Financial Difficulty	____
Emotional Abuse	____
Physical Abuse	____
Sexual Abuse	____
Alcohol Abuse	____
Drug Abuse	____
Other:__________	____

POSSIBLE ISSUES

SUBSTANCE ABUSE

Do you use drugs? ___ No ___ Yes Regularly? Occasionally? How does your usage affect your life?)____
What drugs have you taken:
_____Depressants: Alcohol, Tranquilizers, Sleeping Pills, Inhalents
_____Stimulants: Cocaine, Crack, Crank, Speed, Diet Pills
_____Stimulants: Caffeine, Nicotine
_____Narcotics: Heroin, Codeine, Morphine
_____Hallucinogens: LSD/Acid, PCP, Peyote, Shrooms
_____Cannabis: Marijuana
_____Other:_______________________
When did you first use?_______________________________When did you last use?_________________________

SUICIDE/HOMICIDE

Have you ever had or do you have:	Past	Now
Thoughts of hurting yourself?	______	______
Thoughts of committing suicide?	______	______
Plans to commit suicide?	______	______
Attempts to commit suicide?	______	______
Threats to commit suicide?	______	______
Thoughts of harming someone?	______	______
Plans to harm someone?	______	______
Attempts to harm someone?	______	______
Threats to harm someone?	______	______
Actually harmed someone?	______	______

DEPRESSION

Has you ever or do you now have:	Past	Now
Inability to sleep or sleeping longer?	______	______
Increased or decreased appetite?	______	______
Tearfulness or feelings of despair?	______	______
Lack of energy or feelings of fatigue?	______	______
Preoccupation with life events?	______	______
Decreased contact with others?	______	______
Feelings of depression?	______	______
Decreased interest in pleasurable activities	______	______

Is there anything else that may be helpful for your counselor to know that we have not asked?______________________________