PERSONAL HISTORY – MINOR INTAKE (Adolescents)

Client's Name: _____ Date: _____

Gender: ___F ___M Date of Birth: ___/___/_____ Age: _____ Grade in School: _____

Form completed by (if someone other than client):_____ Relationship: _____

Address: _____ City: _____ Zip:_____

Check Preferred Phone □(home): _____ □(work): _____ □(cell): _____

Okay to leave messages □Voice □ Text Email:_____

Emergency Contact: _____ Phone: _____

Relation: _____

Primary reason(s) for seeking services:

____ Anger management ____ Anxiety ____ Self-Harming Behaviors ____Depression

____ Eating disorder ____ Relationship issues ____ Sexual Abuse ____ Fear/phobias

____ Sleeping Disturbance ____ Suicidal Ideations ____School Issues ____ Hyperactivity

____ Self-Esteem ____ Impulse Control ____ Inattentiveness ____ Other concerns

Please explain all checked responses:_____

_____

Duration of above symptoms:_____

_____

Past Counseling Experience: _____

(Year/Date) **(Duration)**

CURRENT FAMILY STRESSORS: Have any of the following stressful events occurred within the past 12 months?

_____ Parents divorced or separated _____ Family accident or illness ____ Death in family

_____ parent changed job _____ Changed schools ____ Family moved

_____ Family financial problems _____ Other (please specify) _____

Family History

Client's Mother

Name: _____ Age: _____ Occupation: _____ FT: ___ PT: ___

Relationship to adolescent: □Natural Parent □Step-parent □Adopted □Foster parent □Other: _____

Day phone: _____ Evening Phone: _____

Client's Father

Name: _____ Age: _____ Occupation: _____ FT: ___ PT: ___

Relationship to adolescent: □Natural Parent □Step-parent □Adopted □Foster parent □Other: _____

Day phone: _____ Evening Phone: _____

Client's Parent History

With whom does the client live with at this time? _____

Were the client's parents ever married? ___No ___Yes

Are parent's divorced or separated? ___No ___Yes If "Yes", who has legal custody? _____
Is there significant information (present of past) about the parents' relationship or treatment toward the child which might be beneficial in counseling? ___No ___Yes If "Yes", please describe: _____

_____

Client's Siblings and Others Who live in the Household

Names of Siblings	Age	Gender	Lives	Quality of Relationship with the Client
_____	____	___F ___M	___Home ____Away	___Poor ___Average ___Good
_____	____	___F ___M	___Home ____Away	___Poor ___Average ___Good
_____	____	___F ___M	___Home ____Away	___Poor ___Average ___Good
_____	____	___F ___M	___Home ____Away	___Poor ___Average ___Good

Others Living in the Household	Age	Gender	**Relationship** (Cousin, grandparent, etc.)	Quality of Relationship with the Client
_____	____	___F ___M	_____	___Poor ___Average ___Good
_____	____	___F ___M	_____	___Poor ___Average ___Good
_____	____	___F ___M	_____	___Poor ___Average ___Good

Relationship information that would be beneficial for counseling: _____

_____

Family Health History

Have any of the following diseases occurred among the adolescent's blood relatives? (Parents, siblings, aunts, uncles, or grandparents) Check those which apply:

□ Allergies
□ Anemia
□ Asthma
□ Bleeding tendency
□ Blindness
□ Cancer
□ Cerebral Palsy
□ Cleft lips/Palate
□ Deafness
□ Diabetes
□ Glandular problems
□ Heart disease
□ High blood pressure
□ Kidney disease
□ Learning disabilities
□ Mental illness
□ Migraines
□ Multiple sclerosis
□ Muscular Dystrophy
□ Nervousness
□ Perceptual motor disorder
□ Mental retardation
□ Seizures
□ Sexual abuse
□ Substance abuse
□ Suicide
□ Other

Comments and descriptions regarding family health history: _____

_____

Cultural / Ethnic

To which cultural or ethnic group, if any, do you belong? _____

Is client experiencing any problems due to cultural or ethnic issues? ___ No ___ Yes

If "Yes", please describe: _____

Other cultural / ethnic information you feel is pertinent for your counselor: _____

Education

Current school: _____ Type: ___ Public ___Private ___Home schooled ___Other:_____

Has the client had counseling sessions with their school counselor? ___No ___Yes, currently ___Yes, previously

If "Yes", please describe: _____

In special education? ___No ___Yes If Yes, please describe: _____

In gifted program? ___No ___Yes If Yes, please describe: _____

Has the client ever been held back in school? ___No ___ Yes If Yes, please describe: _____

Has the client ever been suspended: ___No ___Yes If Yes, please describe_____

Have there been recent changes in the client's grades? ___No ___Yes If Yes, please describe:_____

_____

Has client ever attempted or ran away from home or school? ___No ___Yes If Yes, please describe: _____

_____

Does client have any problems at school? _____

_____

Client Medical / Physical Health

□ Abortion	□ Asthma	□ Blackouts	□ Diabetes
□ Dizziness	□ Heart Trouble	□ Hepatitis	□ Hives
□ Meningitis	□ Miscarriage	□ Pregnancy	□ Seizures
□ Severe head injury	□ Thyroid disorder	□ Sexually transmitted disease	□ Other _____

Please explain all checked: _____

_____

List any current health concerns: _____

List any recent health or physical changes: _____

Please check if there have been any recent changes in the following:

□ Sleep patterns	□ Eating patterns	□ Physical activity level	□ Energy level	□ Mood
□ Behavior	□ Weight	□ General disposition	□ Nervousness	□ Continence

Describe the changes in areas checked above: _____

_____

Medications

Currently prescribed medications	Dose	Frequency	Date Started	Purpose	Side Effects
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes
Current over-the-counter meds	**Dose**	**Frequency**	**Date Started**	**Purpose**	**Side Effects**
_____	_____	_____	_____	_____	□No □Yes
_____	_____	_____	_____	_____	□No □Yes

List any medication allergies: _____

Chemical Use History

Does the client use or have a problem with alcohol or drugs? ___No ___Yes

If Yes, please describe: _____

_____

Therapeutic Goals

What are the guardian goals for the adolescent's therapy? _____

_____

_____

What are the adolescent's goals for therapy? _____

_____

_____

What family involvement would you like to see during the therapeutic process? _____

_____

_____

Do you believe your adolescent is suicidal at this time? ___No ___Yes

If Yes, please explain: _____

_____

_____

For Staff Use

Therapist's comments: _____

_____

_____

_____

Therapist's signature/credentials: _____ Date: _____

Supervisor's comments: _____

_____

_____

_____

Supervisor's signature/credentials: _____ Date: _____