

Confidential Client History For Teens

The purpose of this questionnaire is to help your counselor get a good picture of you. By completing these questions as best as you can, you will be helping your counselor to understand you and your particular situation and needs. Everything will be kept in private, between you and the counselor. The only time the counselor can tell your parents or anyone else anything is if you give your permission. The only other time, is if the counselor feels you are going to hurt someone or you are going to be hurt and a solution between you can't be worked out.

Name _____ Nickname _____

What is your main problem today?

What are some ways you have tried to solve this problem before?

Health/Medical History

Please check those you have been having trouble with:

- | | |
|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Unwanted thoughts |
| <input type="checkbox"/> Feeling afraid | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Feeling all alone | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Waking up a lot at night | <input type="checkbox"/> Waking up real early |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Less hungry lately |
| <input type="checkbox"/> Overeating | <input type="checkbox"/> Afraid to eat |
| <input type="checkbox"/> Sad most of the time | <input type="checkbox"/> Angry most of the time |
| <input type="checkbox"/> Not being able to control
your anger | <input type="checkbox"/> Not interested in things you
used to do anymore |
| <input type="checkbox"/> Upset stomach or feeling
that you need to throw up | <input type="checkbox"/> Having to repeat the same
things over and over |

Have you ever thought of hurting yourself? Yes No
If yes, have you ever tried to hurt yourself? Yes No

Do you ever feel that you could hurt someone else? Yes No
Have you ever hurt someone else? Yes No

Family Information

What is the thing you like best about your parents or family? _____

Who in your family do you feel the closest to? Why? _____

Please check any that have happened in your family:

- | | |
|--|--|
| <input type="checkbox"/> Parents don't live together | <input type="checkbox"/> We have lots of money problems |
| <input type="checkbox"/> Somebody died | <input type="checkbox"/> Someone drinks too much |
| <input type="checkbox"/> Someone takes drugs | <input type="checkbox"/> Someone is very sick |
| <input type="checkbox"/> Someone hits | <input type="checkbox"/> Someone has problems with the law |
| <input type="checkbox"/> Other _____ | |
-

Alcohol/Drug History

Have you ever used alcohol or drugs? Yes No

If yes, what did you use? _____

When and why did you use? _____

Do you think anyone in your family has a problem with alcohol or drugs? Yes No

Who? _____

School History

Is there anything that bothers you about school? Yes No

If yes, what? _____

What do you like best about school? _____

What are your friends like? _____

Why did you choose them to be your friends? _____

Where do you usually go and what do you usually do after school? _____

Self-Description

What do you like least about yourself? _____

What do you like most about yourself? _____

If you could change anything in your life, what would it be? _____

Please tell me about any hobbies or things you are interested in (i.e. music, sports, church, other): _____

If you would like to tell me anything else, please use the bottom or back of this page.

I, _____, understand that this counselor might speak to his or her supervisor and consultant if they need help with my case. If they do, the supervisor and the consultant will also keep everything shared among themselves. Everything will still be kept private.

Teen's Signature _____ Date _____