ADOLESCENT INFORMATION SHEET
(To be completed by Parents/Legal Guardians)

Please provide the following information and answer the questions below and bring the completed form to the first session.

*Please note: information you provide here is protected as confidential information.**

Today's Date: _____

Adolescent's Name: _____ Birth date: ___/___/___ Age: ____
Gender Identity: _____ Preferred Pronouns: _____
Address: _____
Phone: (____) _____ May I leave a message? □ Yes □ No
E-mail*: _____ May I email you?* □ Yes □ No

Parent/Guardian 1:
Name: _____
Address: _____
Phone: (____) _____ May I leave a message? □ Yes □ No
E-mail*: _____ May I email you?* □ Yes □ No

Parent/Guardian 2:
Name: _____
Address: _____
Phone: (____) _____ May I leave a message? □ Yes □ No
E-mail*: _____ May I email you?* □ Yes □ No

**Please note: Email correspondence is not considered to be a confidential medium of communication.*

Referred by (if any): _____
School:_____ Grade: _____

How does your adolescent do in school academically? _____
_____

How does your adolescent do in school behaviorally and socially ?_____
_____

Does your adolescent have learning or physical challenges? Yes ___ No ___ Maybe ___
Specify: _____

Does your adolescent have a mental health diagnosis? Yes __ No ___ Specify: _____
_____

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Does your family have specific spiritual beliefs or religious affiliations? _____
_____
_____

Adolescent's race/ethnicity? _____
Which language(s) are spoken at home? _____

Medical History

During pregnancy, did mother use:
Cigarettes ___ Alcohol ___ Drugs ___ Experience Extreme Stress ___
If so, please specify frequency, amounts, and duration: _____
_____

List any birth complications (Ex: Premature, jaundice, C-section, etc.)_____
_____

Reached developmental milestones: On time ___ Early ___ Late ___
Describe if significant _____

List adolescent's medical history (e.g., surgeries, broken bones, etc.)_____
_____
_____

Does your adolescent use: Cigarettes ___ Alcohol ___ Drugs ___ Vaping ___
Do you have concerns about your adolescent's substance use?
If so, please explain: _____
_____

Primary Care Physician: _____ Phone:_____
Last seen on: _____

Psychiatrist: _____ Phone:_____
Last seen on: _____

Current medications: (Include dosage and frequency):_____
_____
_____
Any medication allergies? _____
_____
Other allergies? _____
How many times has the adolescent moved homes? _____

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Family History

Parent 1:_____ DOB:_____
Parent 2:_____ DOB:_____

Siblings (1st to last): Living at home?
Name: _____ Age: ____ _____
Name: _____ Age: ____ _____
Name: _____ Age: ____ _____
Name: _____ Age: ____ _____
Name: _____ Age: ____ _____
Name: _____ Age: ____ _____
Name: _____ Age: ____ _____

Other people living in the household, if not listed above: _____
_____
_____
_____

Is the adolescent adopted? Yes ___ No ___ If yes, when adopted? : _____

Are the adolescent's parents living together? Yes ___ No ___
If no, how old was the adolescent when the parents were separated? _____ years

Parent 1
Occupation: _____
Highest level of education: _____

Parent 2
Occupation: _____
Highest level of education: _____

If separated or divorced, visitation schedule: _____
_____
_____

What is the legal custody arrangement regarding physical and mental health care: _____
_____
_____

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Please describe your immediate and extended family mental health history. (Ex: Depression, anxiety, eating disorders, bi-polar disorder, suicide attempts, alcoholism, other drugs and addiction issues, domestic violence, obsessive compulsive behavior, phobias/panic, ADHD, schizophrenia, etc. _____

How would you describe your adolescent's relationship with his/her family (parents, stepparents, siblings)? _____

If you are married, how would you describe your marriage? _____

If you are divorced, separated, or living separately from your adolescent's mother/father how would you describe your relationship with each other? _____

Please note any significant changes in the course of your adolescent's life and their adjustment to them (i.e. losses, moves, changes in friends, peers, health issues):

How is your adolescent disciplined? Please list each method and frequency of use: _____

What are your adolescent's responsibilities at home? _____

How well does your adolescent handle these responsibilities? _____

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Trauma History

Has your adolescent been verbally abused? __Y, __N, __Suspected. Specify: _____

_____

_____

Has your adolescent been physically abused? __Y, __N, __Suspected. Specify: _____

_____

_____

Has your adolescent been sexually abused? __Y, __N, __Suspected. Specify: _____

_____

_____

Other stressors or traumas (either experienced or witnessed)? _____

_____

_____

Symptoms

Please review the below list and indicate with a checkmark the degree of severity for any symptoms your adolescent is experiencing.

SYMPTOM	MILD	MOD	SEVERE	SYMPTOM	MILD	MOD	SEVERE
SADNESS				SOCIAL ISOLATION			
CRYING				PARANOID THOUGHTS			
PROBLEMS AT HOME				INDECISIVENESS			
HYPERACTIVITY				LOW ENERGY			
BINGING/PURGING				EXCESSIVE WORRY			
LONELINESS				POOR CONCENTRATION			
UNRESOLVED GUILT				LOW SELF WORTH			
IRRITABILITY				ANGER ISSUES			
NAUSEA/INDIGESTION				IDENTITY QUESTIONS			
SOCIAL ANXIETY				HALLUCINATIONS			
SELF HARM/CUTTING				RACING THOUGHTS			
IMPULSIVITY				RESTLESSNESS			
NIGHTMARES				DRUG USE			
HOPELESSNESS				ALCOHOL USE			
ELEVATED MOOD				EASILY DISTRACTED			
MOOD SWINGS				TRAUMA FLASHBACKS			
ANOREXIA				OBSESSIVE THOUGHTS			
GRIEF				PANIC ATTACKS			
PHOBIAS				FEELING ANXIOUS			
HEADACHES				FEELING PANICKY			
CHANGE IN WEIGHT				SUICIDAL THOUGHTS			
CHANGE IN APPETITE				HOMICIDAL THOUGHTS			
DIFFICULTY SLEEPING				SELF-HARM THOUGHTS			
DIFFICULTY REMEMBERING THINGS				PERFECTIONISM			
LACKING MOTIVATION				OTHER			

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What are five adjectives that describe your adolescent? _____

What do you view as your adolescent's major strengths and positive traits?_____

What are your adolescent's activities and/or hobbies? _____

What are some of the influential and supportive people and/or beliefs in your adolescent's life?

Briefly describe your goals for your adolescent's therapy: _____

Please list any information you deem to be important for the therapist to know:

Who shall I contact in case of emergency?

Name: _____
Phone (____)_____
Relationship _____

Special Confidentiality Notice for Parents
(this notice is also provided to your adolescent in their info packet)

I strongly believe that for therapy to be helpful to an adolescent there needs to be as much confidentiality for them as possible in the therapy process. If an issue falls into the following

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categories…

-- your adolescent is clearly unsafe or at risk of harming themselves
-- your adolescent is at risk of being harmed by anyone else
-- your adolescent is at risk of harming someone else
-- we are required by a court to disclose treatment records

…I will follow the clinically and legally appropriate reporting requirements. Outside of this, I will encourage your adolescent to express themselves freely, and assure them that there will be confidentiality provided to them in this process. I need your adolescent to be open and honest with me in order to understand and treat the full range of issues your adolescent is facing, and they may be too scared, angry, or ashamed right now to share those issues with you. I also recognize it is very important for you to know what your adolescent is going through in order to do your job as a parent, which is why I will always encourage your adolescent to be open and honest with you. I will encourage, prepare, and support your adolescent so that they feel safe enough to share those issues with you, and I am happy to facilitate family meetings whenever helpful and appropriate.

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