CenterLife Counseling

Centerville Clinic
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Phone: 651-288-0332 Fax: 651-288-0493

White Bear Lake Clinic
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Phone: 651-289-3111 Fax: 651-289-3113

Date: _____

Adolescent Information Form

All information on this form is considered strictly confidential within the guidelines of the clinic.

Name _____ **DOB** _____ **Age** _____

How did you hear about us? Insurance Friend/Family Web/Social Media Newspaper Other _____

Please describe the reason for your visit to our clinic: _____

_____

How upsetting is this issue for you? (on a scale of 1-10, with 1=not upsetting, 10=most upsetting): _____

Please indicate how much this bothers you:

In Daily Life	Not at all	Minimally	Moderately	Significantly/Severely
Academically	Not at all	Minimally	Moderately	Significantly/Severely
Within Your Family	Not at all	Minimally	Moderately	Significantly/Severely
With Friends or Socially	Not at all	Minimally	Moderately	Significantly/Severely

How long has this been bothering you? _____

What resources do you have to help you work through this issue? _____

_____

_____

Symptoms/Issues *(Check all that apply)*

_____ Anxious, worried
_____ Anger, aggression, or violence
_____ Attitude issues
_____ Bored
_____ Bullying: By others To others
_____ Confused
_____ Cutting, burning, or hurting yourself
_____ Counting or ordering of things
_____ Concentration or focus issues
_____ Conflicts with adults (parents, teachers, etc.)
_____ Conflicts with others (friends, other kids)
_____ Crying or tearful
_____ Depressed mood
_____ Difficulty being alone
_____ Disorganized
_____ Drug or alcohol issues
_____ Easily distracted
_____ Easily irritated
_____ Fatigued or tired often
_____ Fears (monsters, snakes, people, etc.)
_____ Guilt feelings/shame
_____ Hyperactive
_____ Impulsive
_____ Legal issues
_____ Living arrangement issues
_____ Lying frequently
_____ Lonely
_____ Money issues
_____ Mood swings
_____ Motivation reduced or absent
_____ Overly worried about germs, organization
_____ Panic attacks
_____ Perfectionism
_____ Physical problems (stomach, headache)
_____ Self-esteem low
_____ Sexual identity concerns
_____ Sexual issues
_____ School or employment issues
_____ Shy or uneasy around others
_____ Unassertive
_____ Unwanted behaviors or thoughts
_____ Withdrawn or alone too much

Symptoms/Issues *(Continued)*

_____ Energy levels
__ Too much energy __ Too little energy

_____ Sleep problems
__ Trouble falling asleep
__ Trouble staying asleep
__ Trouble sleeping too much/too little

_____ Eating habits
__ Binging (eating much more than you need or is normal for you, in a specific time period)
__ Purging (making yourself throw up after you eat)
__ Restricting (not eating enough or not eating at all)
__ Overeating (consistently, over time)
__ Using laxatives to control weight

_____ Weight changes
__ Increase Please describe: _____
__ Decrease Please describe: _____

_____ Behavior problems
__ At home
__ At school/after school
__ At work
__ With friends/In social settings

Things You Worry About or Feel Bad About *(Check all that apply)*

_____ Being popular
_____ Being left out
_____ Being bullied
_____ Being excluded
_____ Being sick a lot
_____ Being criticized by others
_____ Being suspicious of others
_____ Being taken advantage of by friends
_____ Being involved with pornography
_____ Being uncomfortable with the opposite sex
_____ Conflicts with brothers/sisters
_____ Conflicts with parents/step parents
_____ Feeling used or pressured to have sex
_____ Feeling pressured to do something against your will
_____ Getting or being pregnant
_____ Getting angry a lot
_____ Getting in fights a lot
_____ Arguing or competing with others too much
_____ Trying to get your way most of the time
_____ Thinking you are right all the time
_____ Having trouble living up to others' expectations
_____ Trying to please everyone
_____ Upsetting someone if you say "no" to them

_____ Your brother/sister
_____ Your parents
_____ Your friends
_____ Your appearance
_____ Your grades
_____ Your family
_____ Yourself
_____ Money problems
_____ Not having enough close friends
_____ Not knowing enough about sex
_____ Not fitting in with others
_____ Others putting you down
_____ Others having a bad opinion of you
_____ Problems with boyfriend/girlfriend
_____ Same sex attraction
_____ Sex
_____ School problems
_____ The way you treat other people
_____ The way others treat you
_____ Thinking about sex too much
_____ Other: _____
_____ Other: _____

Problems in Your Family that You Are Worried About *(Check all that apply)*

_____ Parent is physically sick
_____ Parent has an emotional or mental problem
_____ Parent has trouble with alcohol or drugs
_____ Parents are fighting
_____ Parents are divorcing or are divorced
_____ Parents are never home or are gone a lot
_____ Arguing with step-parent
_____ Can't talk to parents/step-parents
_____ Don't feel close to family

_____ Brother or sister is physically sick
_____ Brother or sister has an emotional problem
_____ Brother or sister has trouble with alcohol/drugs
_____ Family fighting
_____ Don't have enough privacy
_____ Have too many chores
_____ Parents disapprove of clothes, appearance
_____ Parents disapprove of friends
_____ Parents disapprove of activities, music

Problems in Your Family that You Are Worried About *(Continued)*

_____ Don't want to live at home
_____ Parents expect too much
_____ Parents favor brothers/sisters
_____ Feel ignored by my family

Background Information

Biological (Birth)/Adoptive Parents:

Name Age Education Occupation

If your biological (birth)/adoptive parents are not together, please fill in the following information for your step-parents or your parent's boyfriend/girlfriend. ☐ Does Not Apply

Name of parent Name of Step-parent or Boy/Girlfriend Age Occupation

If your parents are not together, please describe the custody or visitation arrangements for you. ☐ Does Not Apply

Are there any current court proceedings related to custody which involve you? Y N ☐ Does Not Apply

If yes, please describe:

If you are adopted or in a foster home, do you see your biological (birth) parents? Y N ☐ Does Not Apply

If yes, please describe how often and where you see them.

If no, please share why you do not see your biological parents.

Have you ever lived some place other than your home, such as a shelter, a group home, etc.? Y N

If yes, please provide details:

Have you ever been arrested or placed on probation? Y N

If yes, what are the details/specifics of your arrest and/or probation?

Siblings: *Indicate if A (adoptive), H (half), or S (step)* ☐ Check of you don't have siblings

Name Age Grade/Education Physical/Emotional Health History

Children: Number of pregnancies: _____ ☐ Check if you don't have children

Name Age Name of child's other parent Physical/Emotional Health of child

_____

_____

Are both parents involved in your child's life? Y N

Please describe the custody arrangements for your child. _____

_____

Currently live in: Single Family Home Apartment/Condo Townhouse/Condo Mobile Home Other: _____

List any others living in your house and the reason they are in your house (ex: grandparents or step-siblings that live in your house for part of the week). ☐ Does Not Apply

Name Age Relationship to You Reason in your house

_____

_____

Safety

Do you have a history of abuse?

Physical Y N
If yes, when and please describe: _____
Sexual Y N
If yes, when and please describe: _____
Emotional Y N
If yes, when and please describe: _____
Verbal Y N
If yes, when and please describe: _____
Neglect Y N
If yes, when and please describe: _____
Domestic Abuse Y N
If yes, when and please describe: _____
Other Y N
If yes, when and please describe: _____

Have you ever experienced:

Suicidal Thoughts Y N
If yes, when and please describe: _____
Suicide Attempts Y N
If yes, when and please describe: _____
Self-harm Y N
If yes, when and please describe the type of harm: _____

History of the Problem

Please describe any changes you've had recently, which might be upsetting to you (such as moving, a death in the family, change of schools, birth of a sibling, financial/legal problems, death of a pet, etc.). _____

_____

_____

How have you tried to adjust to the change? Please list things that *have* worked as well as things that *have not* worked.

Family Interaction

What do you do together as a family?

How does your family express feelings?

How often are there conflicts in your family?

What are the conflicts typically about?

How are these conflicts resolved?

Who is typically in charge of discipline in your family?

What type of discipline is used in your family?

Family History/Culture/Beliefs

What is your family cultural background (ethnic or racial origin)?

What is your family religious background?

Please list any cultural or religious traditions that are important to you.

What is your primary language?

Secondary language(s):

What is your sexual orientation?

School History

What school do you go to?

What grade are you in?

What kind of grades do you usually get?

Have there been any changes in your grades recently? Y N

If yes, please describe:

What are your favorite classes?

What are your least favorite classes? _____

Have you had any problems with friends, other kids, or teachers? Y N

If yes, please describe: _____

Have you ever been given detention, suspended, or expelled from school? Y N

If yes, please describe: _____

Have you been late for school and/or absent from school a lot? Y N

If yes, please describe: _____

Psychological/Mental Health History

Are you going, or have you gone, to see the school counselor, school psychologist, or school social worker? Y N

If yes, please provide details: _____

_____

Please list any Counseling or Therapy you have had ☐ Does Not Apply

Clinic or Therapist Name	Dates of Services (from-to)	Reason/Diagnosis

Please list any previous times you have been in the hospital for your mental health ☐ Does Not Apply

Hospital/Clinic	Dates of Services (from-to)	Reason/Diagnosis

Medical History

When was the last time you saw the doctor? _____

Please list any medical problems you've had in the last year: _____

_____

Medications: ☐ Check if you are not taking any medications

Name of Medication and Dosage	Reason for the Medication	Length of time you have taken it

Please indicate if you have or have had:

Head Injury	Y	N	If yes, describe: _____
Concussion	Y	N	If yes, describe: _____
Car Accident	Y	N	If yes, describe: _____
Surgeries	Y	N	If yes, describe: _____
Long-term Illness	Y	N	If yes, describe: _____
Seizures	Y	N	If yes, describe: _____
Allergies	Y	N	If yes, describe: _____
Disabilities	Y	N	If yes, describe: _____

Have you ever been injured while playing any sports (football, hockey, soccer, skiing, cheerleading, etc.)? Y N

If yes, please describe: _____

Social History

How many close friends do you have at this time? _____

How often do you see them? Daily 3-5x's week once a week every other week once a month

What recreation, hobbies, or interests do you have? _____

_____

Please list organized activities/sports you are involved in: (such as Girl/Boy Scouts, community baseball, gymnastics, YMCA, etc.): _____

_____

What do you feel you do well? _____

_____

Job History ☐ Does Not Apply

Do you have a job, either in school or outside school? Y N

Current Employer and your Job Position: _____

What typical days and hours do you work? _____

Previous Jobs: *(Please list any jobs you have had in the past)*

Position Duties Dates (from-to)

_____

_____

Substance Use ☐ Check if you have not used drugs or substances

Please identify your current and past substance use.

Substance	Type	Quantity	Frequency	Age Started & Stopped
Alcohol				
Nicotine/Tobacco				
Illegal Drugs				
Misuse of Prescriptions				
Other				

Please describe your daily caffeine use (such as coffee, soda, energy drinks, etc.). _____

_____

Please answer the following:

1. Have you ever felt you ought to cut down on your drinking or drug use? Y N
2. Have you had people annoy you by criticizing your drinking or drug use? Y N
3. Have you felt bad or guilty about your drinking or drug use? Y N
4. Have you had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover? Y N

Have you experienced negative consequences (DUI, DWI, school failure, etc.) from substance use? Y N

If yes, please provide details: _____

If yes to the above questions, have any of these occurred in the past year? Y N

Please provide details: _____

_____

What is the maximum amount of alcohol/drugs you have had or done on any given day in the past year? _____

_____

Have others who are close to you abused alcohol or drugs? Y N

If yes, please provide details: _____

Are you attending, or have you attended, a self-help group, such as AA, NA, or Alateen? Y N

If yes, please provide details: _____

Chemical Dependency Treatment History: ☐ Check if you do not have a history of CD treatment

Name of Program/Provider	Inpatient/Outpatient	Dates (from-to)

Client Expectations

How do you feel about coming to therapy? _____

_____

What goals do you have for therapy? _____

_____

What research have you done related to the reason for your visit? _____

_____

How long do you expect to be in therapy? _____

How often would you like to come to therapy? _____

What else do we need to know that we have not asked? _____

_____

_____

_____