

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?

CFGC Adolescent/Teen Information con't

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? _____

CFGC Adolescent/Teen Information con't

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?

CFG Adolescent/Teen Information con't**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? _____