Therapist:_____ Client Name:_____

SOLUTION BASED COUNSELING SERVICES, LLC

CLIENT INFORMATION PACKET – ADOLESCENT (14-17 years old)

Name of person completing this form:_____

Relationship to client:_____ Who referred you to us?:_____

Reason you are coming in for treatment:_____

_____

How do you feel about treatment?:_____

What would you like to achieve in counseling?:_____

_____

PERSONAL SYMPTOMS

Please circle all of the items that you are experiencing.

Anxiety	Panic Attacks	Obsessive or Compulsive Behavior
Depression	Crying Spells	Hopelessness
Relationship Problems	Relationship Breakup	Anger
Loneliness	Emptiness	Loss of Appetite
Sleep Disturbance	Nightmares	Hearing Voices
Feeling Controlled	Feeling Talked About	Visual Hallucinations
Unusual Thoughts	Frequent Headaches	Careless/Reckless Behavior
Blackout/Memory Loss	Often Sick	Substance Abuse
Food Binging	Purging	Breaking Things
Bullying	Endangering Self	Endangering Others
Learning Problems	Increased Spending	Sexual Behavior
Cannot Concentrate	Confusion	Mood Swings
Racing Thoughts	Fear of Dying	Job Stress
Decreased Activity	Decreased Self Care	Guilt/Shame
Loner	Short Attention Span	School Problems
Harming yourself (Ex: cutting)	Yelling/Screaming	Suicidal Thoughts

Please explain any of the above:_____

_____

_____

How long have these symptoms been happening?:_____

_____

MENTAL HEALTH TREATMENT HISTORY

Have you ever been in Outpatient Mental Health Treatment?: ___Yes ___No When?:_____
Where?:_____
Have you ever been in Inpatient Mental Health Treatment?: ___Yes ___No When?:_____
Where?:_____
Have any family members ever been in Outpatient Mental Health Treatment?: ___Yes ___No Who?:_____
Where?:_____ When?:_____
Have any family members ever been in Inpatient Mental Health Treatment?: ___Yes ___No Who?:_____
Where?:_____ When?:_____

SCHOOL ADJUSTMENT

Name of school:_____ District:_____
What grade are you in?:_____ Have you ever repeated a grade? ___Yes ___No
If so, which grade?:_____ Reason for repeat:_____
Please describe any learning disabilities you may be experiencing:_____
_____
Have you ever been psychologically tested?: ___Yes ___No If yes, when and where?_____
_____
Have you ever received special education services?: ___Yes ___No Please explain:_____
_____
Have you been in trouble at school (Ex: Truancy/Suspension/Fighting)? : ___Yes ___No Please explain:_____
_____
What are your average grades? _____ How do you relate to your peers?: Good Fair Poor

FAMILY INFORMATION

Full Name	Age	Living with you?	Deceased
Father:			
Stepfather:			
Mother:			
Stepmother:			
Siblings:			

Others in the home?:_____
_____
How do you relate to your family members?:_____
Are you adopted?: ___Yes ___No What age?:_____ Who is your legal guardian?_____

RELIGION

Any religious conflicts in the family?: ___Yes ___No Religious preference:_____
Do you practice?: ___Yes ___No Any other religious activities?:_____

MEDICAL HISTORY

Your Physician: Name/Office Name:_____

Address:_____

_____

Phone Number:_____

Name of preferred hospital:_____

Current weight:_____ Current height:_____ Date of last exam:_____

Results:_____

Any current health concerns:_____

Any problems meeting developmental milestones (Ex: Walking/Talking/Potty Training)? ___Yes ___No

Please explain:_____

Are you taking any medications?: ___Yes ___No Please list:_____

_____

Please list any allergies to medications or food:_____

_____

PERSONAL HEALTH INFORMATION

Have you experienced any significant weight changes? ___Yes ___No Explain:_____

_____

Do you exercise regularly?: ___Yes ___No How many days per week:_____

What kind of exercise do you do?:_____

How would you rate your diet?:___Healthy ___Unhealthy ___Mixed Are you concerned about your diet? ___Yes ___No

Please explain:_____

Do you have trouble sleeping?: ___Yes ___No Explain:_____

ABUSE HISTORY

Physical abuse?: ___Yes ___No What age(s)?:_____ How long?:_____

Sexual abuse?: ___Yes ___No What age(s)?:_____ How long?:_____

Verbal abuse?: ___Yes ___No What age(s)?:_____ How long?:_____

Neglect?: ___Yes ___No What age(s)?:_____ How long?:_____

SUBSTANCE ABUSE HISTORY

Do you have a problem with alcohol or drugs?: ___Yes ___No

Any tobacco use?: ___Yes ___No Amount:_____

Any caffeine use?: ___Yes ___No Amount:_____

Other substances used:_____

Age use began:_____

Frequency of use:_____

Date of last use:_____ Number of days used in the last 30 days:_____

INCOME DATA

Any financial problems in the family?: ___Yes ___No Explain:_____

_____

Do both parents work?: ___Yes ___No

LEGAL

Have you ever been involved with the police or juvenile court system?: ___Yes ___No

Please explain:_____

_____

Are you currently on probation?: ___Yes ___No Next court date:_____

Requirements of probation:_____

_____

Are your parents involved in a divorce or custody issue currently?: ___Yes ___No

Please explain:_____

_____

_____

EMPLOYMENT

Occupation Employer Years Employed Reason for Leaving .

_____

_____

Have you ever been fired from a job?: ___Yes ___No How many times?:_____

Reasons:_____

Do you have any problems at your current job?: ___Yes ___No Please explain:_____

_____

_____

Additional Comments:_____

_____

_____

_____

Signature (or Parent/Guardian Signature) Date

_____

Therapist's Signature /Credentials Date

Therapists Comments:_____

_____

_____

_____