ADOLESCENT – SUPPLIMENTAL INFORMATION
(To be filled out by client – ages 12-17)
(Revised July 2013)

Client Name: _____ Today's Date: _____

Phone (cell): _____ E-Mail: _____

(Confidentiality of email communication cannot be guaranteed.)

Facebook Page (optional): _____

Current Family Information

Please list those with whom you currently live and use the following words to describe your relationship (*abusive, bland, calm, conflicted, loving, satisfying, and unfulfilling*):

Name	Age	Relationship	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Educational Information

School: _____ Current Grade Level: _____

What is your current letter grade or grade point average? _____

Which subject(s) are the easiest for you? _____

What subjects(s) are the most difficult? _____

Are you currently behind in any of your class work? Y N

Are you currently under any school disciplinary actions? Detention Suspension Expulsion

Social Information

Who is(are) your best friend(s)? _____

What special interest, skills, or hobbies do you have? _____

What do you do for fun? _____

Please list any extra curricular activities in which you are involved (for example: band, drama, sports, church youth group, etc.):

_____

_____

_____

_____

Relationship Information

Have you ever had a boy or girl friend? Y N

Do you currently have a boy or girl friend? Y N

How would you describe the relationship?

_____

Are you sexually active? Y N

Medical Information

Are you currently taking medication? Y N Do you take it as prescribed? Y N

Please list medications: _____

Are you having trouble sleeping? Y N

Do you have trouble getting to sleep? Y N

Do you have trouble staying asleep? Y N

Do you have recurrent dreams or nightmares? Y N

Do you have trouble concentrating or getting organized? Y N

Have you noticed a recent change in your weight in the last 3-6 months? Y N

Gain or loss? How many pounds? _____

Have you noticed a recent change in appetite? Y N

Increase or Decrease?

Do you have any unexplained crying spells? Y N

Do you often feel any tightness in your chest or throat or heart palpitations? Y N

*(**Palpitation(s)** means an abnormality of heartbeat that ranges from often unnoticed skipped beats or accelerated heart rate to very noticeable changes accompanied by dizziness or difficulty breathing.)*

Do you often feel "nervous" or "anxious"? Y N

Do you often complain of headaches or stomach aches? Y N

Have you ever been diagnosed with any of the following conditions? (please circle all that apply)

Anorexia Anxiety Attention Deficit Disorder (ADD)
Attention Deficit Hyperactivity Disorder (ADHD) Bi-polar Disorder
Borderline Personality Bulimia Conduct Disorder Depression
Learning Disability Oppositional Defiant Disorder (ODD)

Substance Use Information

Do you or have you used any of the following?

Alcohol Marijuana Tobacco (smoke or chew) Other: _____

How often? Daily Weekly Regularly Occasionally

Under what conditions? Alone With a friend At a party

Do you have a history of other addiction issues? (gambling, video games, sex,. pornography?) Yes No

If yes, please describe: _____

Abuse Information

Have you been exposed to any substance use/abuse? Yes No

If yes, please describe: _____

Have you experienced any emotional abuse? Yes No

If yes, please describe: _____

Have you experienced any physical abuse? Yes No

If yes, please describe: _____

Have you client experienced any sexual abuse? Yes No

If yes, please describe: _____

Spiritual Information

What is your spiritual/religious background? _____

Do you practice any type of religion or spirituality? (Please circle) Y N

Buddhism Christianity Mormonism Islam Judaism Other

Are you a member of a local church, mosque or synagogue? Y N

Congregation:_____

How often do you attend? _____

Do you have a favorite Bible story, verse or character? Y N

If yes, please explain:_____

How do you maintain or nurture your spiritual life?

_____

_____

Presenting Information

What is the problem for which you are coming to talk about today? _____

_____

_____

What changes would you like to occur as a result of counseling? _____

_____

_____

What about your life is currently most stressful and why? _____

_____

Miscellaneous Information

Please feel free to tell us anything about your situation that we have not already asked:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Client Signature Date

_____ _____

Counselor Signature and Credentials Date