In order to provide the best treatment possible, please complete this questionnaire. If you are unsure about any item, or feel uncomfortable answering, please leave that part blank, and if you like, we can discuss it together in session. The information you provide is protected as confidential.

:::::Adolescent Form:::::

Client Demographic Information for

Full legal name: ___________________________________ Date of birth: ___________________

Home address: ____

Phone:
(home) ________________ Is it okay to leave you a message at this number? Yes___No___
(cell)___________________ Is it okay to leave you a message at this number? Yes___No___

Email address: _________________________________Is your email address confidential? Yes __No__
Please be advised that email is not the most secure form of communication.

Gender: _________________ Sexual orientation: ____________________

Ethnic/cultural background: __________________ Native language: _____________________

Religious/Spiritual orientation: _______________ Year in School:________________
Do you have a job?________ Relationship status: ______Length of time together:__________________
Emergency contact #1 name:___________________________________ phone number:______________

Emergency contact #2 name:___________________________________ phone number:______________

Do you have any children? If so what are their names and ages: __________________________________

Reason for Seeking Treatment

Please describe your reason(s) for seeking treatment at this time; include date or month or year the problem started: ____

____

Was there an event which made these issues or problems surface? Yes ____ No ____

If yes, please describe: ____

Please indicate how any of the following symptoms may be bothering you

	No Problem	Mild Problem	Moderate Problem	Severe Problem
Depression				
Anxiety				
Controlling stress				
Loss of a loved one				
Problems at work or school				
Loneliness				
Problems coping				
Abuse/victimization				
Financial Problems				
Legal Matters				
Relationship issues				
Sexuality				
Sexual issues				
Family conflict				
Eating and or body image issues				
Eliminating drug/alcohol habit				

Other, please specify:

____

What results do want from treatment?

____

____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas in your life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationship						
Family						
Job/School performance						
Friendships						
Physical health						
Financial situation						
Anxiety level						
Mood						
Eating habits						
Sexual functioning						
Sleep habits						
Ability to concentrate						
Ability to control temper						
Spirituality						

What coping strategies have helped?____

____

Not helped? ____

Have you had any mental health treatment in the past? (please include names and dates if possible)

____

____

Have you ever been hospitalized due to mental health symptoms? (if yes please include when and for what reasons)

____

____

Was there anything during these treatment episodes that was particularly helpful or unhelpful?

____

____

Substance Use

Do you currently struggle with substance abuse or dependence? _________
If yes please indicate what type of substance you struggle with______________________________
How much do you use and how often?____
Age of first use________________ Date of last use_______________
Have you ever experienced withdrawal symptoms, seizures and/or black outs?_____________________
In the past have you struggled with substance abuse or dependence? (if yes please explain)

____

Have you ever had treatment for substance use? (If yes, please indicate when, where and what type of treatment.)

____

____

Do you use any substances recreationally (please include alcohol, marijuana, tobacco or other substances)

____

____

Do you drink caffeine, if so how much?____

Medical History

Do you have any allergies to food and/or medications? If yes, please describe: _____________________

Name and number of Primary Care Physician____

Please list any prescription medications you currently use including any psychiatric medications:

____

____

Does anyone besides your PCP prescribe your medications? If so please indicate name and number

____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc., include name, dosage, and frequency: ______________________________

____

How often do you exercise? ____

Any recent weight gain?______________________ weight loss?______________________________

Have you ever struggled with an eating disorder or do you currently struggle with one?____________

Do you engage in any of the following eating disorder behaviors: Purging, binging, restricting, over exercising? If yes, how often?____

Do you have any current medical diagnoses and if so please list _________________________________

are you being treated for this/them? If yes please share who is providing treatment _________________

Do you have any medical symptoms or complaints that you are currently experiencing? Please explain.

____

____

Have you ever been hospitalized for a medical issue/ had any significant surgeries or procedures? If yes please state why and when ____

Family History

Has anyone in your family ever experienced any Mental Health struggles? If yes please explain

____

____

Has anyone in your family ever experienced any substance abuse / dependence issues? If yes, please explain

____

____

Has anyone in your family had any significant medical problems _________________________________

How many siblings do you have?___________ Where are you in the birth order? ___________________

What is your parent's marital status? __________________ if divorced how old were you?___________

How would you describe the nature of your relationship with your family? ________________________

More about you

What are some of your hobbies/ interests?

____

What would you consider to be some of your weaknesses?

____

What would you consider to be some of your strengths?

____

____

Is there anything else that you would like me to know about you that you have not already shared?

____

____

Thank you for providing me information regarding your health and well-being. I will use this information to build a treatment designed specifically to meet your needs. Please feel free to discuss any aspect of your responses with me. Thanks for your time filling out this form -*Meredith Mirsepassi*