Authenticity Counseling
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TEEN HISTORY QUESTIONNAIRE

Please bring this completed form to your initial appointment.

Client's Name:	Gender:	Birth Date:	Age:
Form Competed by (if other than client):		E-mail:	
Today's Date:	Home Phone:		
Address:	Cell Phone:		
City:	State:	Zip:	
Primary Care Provider (PCP):		PCP Clinic:	
PCP Phone:		PCP Fax:	
Referral Source:			

May we leave a message on your? ☐ home phone ☐ cell phone
May we send mail to your home? ☐ yes ☐ no
May we e-mail you? ☐ yes ☐ no
*please note that email is not considered to be a confidential medium of communication

Parent/Guardian Information

Mother _____ ☐ Sole Custody ☐ Joint Custody
(name) *(best contact number)*

Father_____ Sole Custody ☐ Joint Custody
(name) *(best contact number)*

What are the concerns that brought you here? _____

_____

_____

_____

Are you currently experiencing struggles with:

☐ Anger ☐ Drug / Alcohol Use
☐ Appetite ☐ Energy Level ☐ Sleep
☐ Anxiety / Worry ☐ Homicidal Thoughts ☐ Suicidal Thoughts
☐ Concentration ☐ Panic ☐ Weight
☐ Depression / Sadness ☐ Sexual Activity ☐ Friendships
☐ Occupational Problems ☐ Legal Problems ☐ Family Problems
☐ Health Problems (specify):_____
☐ Other (explain): _____

Have you experienced any of the following in the past year?

□ Financial Stress	□ Family Member's Health Problems	□ New Job
□ Death of a Family Member	□ Started a New Romantic Relationship	□ Lost Job
□ Death of a Friend	□ Major Illness	□ Surgery
□ Ended a Romantic Relationship	□ Moved to a New School	□ Moved

Have you been in therapy in the past? _____Yes _____ No
If so, who did you see, and when?

_____

_____

If yes, was the therapy beneficial? _____

Have you ever been prescribed medication for mental health issues? If so, please list:

_____

Are you currently taking any prescription medications for your physical or mental health? If so, please list: _____

_____

Are you currently taking any over-the-counter medications, aspirins, herbs, and/or vitamins? If so, please list: _____

_____

Please list what you eat in a typical day: _____

_____

_____

Have you □ Binged / □ Purged / □ Restricted (Check all that apply.)
When did you start?_____
When did you stop (if you stopped)?_____
Have you ever been diagnosed with an eating disorder? □Yes □No If yes, specify: _____

_____

History of Behaviors:

□ Aggression to animals	□ Elevated mood	□ Lying
□ Aggression to people	□ Fatigue	□ Memory problems
□ Alcohol / Drug use	□ Friendship problems	□ Mood changes
□ Anger	□ Gambling	□ Low motivation
□ Antisocial behavior	□ Grades inconsistent / low	□ Nightmares / Night terrors
□ Anxiety	□ Guilt	□ Panic attacks
□ Arguing	□ Gang involvement	□ Phobias / Fears, of what:_____
□ Avoiding people	□ Hallucinations	□ Running away
□ Caffeine use	□ Headaches / Migraines	□ School refusal
□ Chest pain	□ Heart palpitations	□ Sexual identity confusion
□ Compulsions / Obsessions	□ Hopelessness	□ Sick frequently
□ Concentration problems	□ Homicidal thoughts	□ Skipping school / Missing work
□ Conflict with peers	□ Hyperactivity	□ Sleeping too much / too little
□ Conflict with parents	□ Impulsivity	□ Speech problems
□ Depression	□ Internet addiction	□ Stealing

☐ Destruction of property
☐ Disorientation
☐ Disorganized thinking
☐ Dizziness
☐ Domestic Abuse
☐ Enuresis
☐ Encopresis
☐ Family Problems
☐ Interrupts frequently
☐ Irritability
☐ Job loss
☐ Judgment errors
☐ Loneliness
☐ Loses temper
☐ Low self esteem
☐ Legal Problems
☐ Stomach aches
☐ Suicidal thoughts
☐ Withdrawing
☐ Work conflict
☐ Worrying
☐ Other (specify): _____

Which drugs have you used or are you currently using?

Currently Use:_____ frequency: _____

Past Use: :_____ frequency: _____

Have you ever received a drinking ticket? ☐ Yes ☐ No If so, when?

Have you ever received a drunk driving ticket? ☐ Yes ☐ No If so, when?

Have you ever blacked out from drinking? ☐ Yes ☐ No If so, when?

Have you ever been treated for alcohol/drug abuse? ☐ Yes ☐ No If so, when?

Has your alcohol/drug use ever caused conflict with family/friends? ☐ Yes ☐ No

Have you ever attempted suicide/planned to hurt yourself? ☐Yes ☐No

If yes, when: _____

Are you currently suicidal or have thoughts of self-harm? ☐Yes ☐No

Have you ever engaged in self-mutilation? ☐Yes ☐No

If yes, when: _____

Do you currently have plans to harm someone else? ☐Yes ☐No

If yes, when, how, and who? _____

Have you ever been hospitalized for <u>psychiatric</u> problems?

If yes, when? _____

Reason?_____

Have you ever been hospitalized for <u>medical</u> problems?

If yes, when? _____

Reason?_____

How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you generally exercise?_____

What type of exercise to participate in? _____

Have you ever been:
Sexually abused □ Yes □ No If yes, Age / By Whom: _____
Physically abused □ Yes □ No If yes, Age / By Whom: _____
Neglected □ Yes □ No

How do you get along with your parents? _____
_____
_____

Are you having any problems with your siblings / family? (if applicable) _____
_____
_____

PARENTING:
What strengths do your parent(s) have? _____
_____

What deficits do your parent(s) have in their parenting style?_____
_____

What types of rules and consequences do your parents use? _____
_____

Who do you live with? (check all that apply)

□ Alone	□ Sister(s)	□ Half sister(s)
□ Parent(s)	□ Step brother(s)	□ Roommate(s)
□ Stepmom / Stepdad	□ Step sister(s)	□ Other (specify):_____
□ Brother(s)	□ Half brother(s)	_____

Do you currently feel safe in your current living situation? □ Yes □ No _____

Is there a history of physical & mental health problems in your biological family? _____
If yes, who/what? _____
_____

Significant Childhood/Adult Stressors: (Check any that apply)

□ Death of parent: Client Age _____

□ Death of Sibling: Client Age _____

□ Divorce: Client Age _____

□ Physical/Sexual abuse: Client's age & Duration _____

□ Domestic Physical Violence: _____

□ Family Alcoholism/Drug Abuse or Dependency: One Parent Both Parents Other

□ Other Stressors: _____

Ethnicity & Religion

What is your cultural / ethnic background? _____

Do you consider yourself to be spiritual / religious? □ Yes □ No

Legal

Do you currently have, or have you ever had, legal problems? □ Yes □ No Date(s): _____

(if yes, please describe.) _____

Education

What grade are you currently in? _____

Where do you go to school? _____

Are you currently employed?

□ Full time □ Part Time □ Laid off □ Student □ Homemaker □ No

Where do you work: _____Title: _____Length of employment:_____

What do you typically do for fun / hobbies? _____

_____

How often do you socialize / go out with friends? _____

What do you do?_____

_____

How many hours per day do you spend on Facebook / Twitter / Internet ? _____

How many hours per day do you spend watching TV? _____

How many hours per day do you spend playing video games? _____

How much / often do you text? _____

How many hours per night do you sleep? _____

What time do you go to bed? _____Wake up? _____Do you have a regular routine? □Yes □No

Do you wake up in the middle of the night to text or answer texts? _____

Are you having any difficulties in your current romantic relationship? _____ If yes, what are they? _____

_____

Are you: □ Heterosexual □ Homosexual □ Bisexual □ Unsure

What do you wish to accomplish in the initial session? _____

_____

What are your goals for therapy? _____

_____

_____

What else would be helpful for me to know that would help with your treatment? _____

_____

_____

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