Check here if a parent/guardian completed this form for the youth [ ]

**Client Name:** _____ **Date:** _____

**Legal Name (if different):** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____ **Gender: M F Age:** ____

**Contact Information** (Please complete information and check boxes below where relevant or available)

| **Legal Guardian?** | | **Phone Messages OK?** |
|---|---|---|
| ☐ Mother | Name _____ | |
| | Home Phone _____ | ☐ Yes ☐ No |
| | Work Phone _____ | ☐ Yes ☐ No |
| | Cell Phone _____ | ☐ Yes ☐ No |
| ☐ Father | Name _____ | |
| | Home Phone _____ | ☐ Yes ☐ No |
| | Work Phone _____ | ☐ Yes ☐ No |
| | Cell Phone _____ | ☐ Yes ☐ No |
| ☐ Legal Guardian | Name _____ | ☐ Yes ☐ No |
| | Contact No. _____ | ☐ Yes ☐ No |
| ☐ Non Legal Guardian | Name _____ | |
| | Contact No. _____ | ☐ Yes ☐ No |

Youth (Client) Contact No. _____ ☐ Yes ☐ No

## Presenting Problem and Treatment Planning

Describe the problem that brought you here today. _____

_____

_____

When did you first notice this problem?

Mark and describe any treatment you have tried for this problem or other problems.

| X | Type | When | Where |
|---|---|---|---|
| | Outpatient Counseling | | |
| | Medication ( Mental Health) | | |
| | Psychiatric Hospitalization | | |
| | Drug/Alcohol Treatment | | |
| | Self-Help/Support Groups | | |

## Mental Health Information

**In the past two weeks,** how often have you experienced the following? Please circle your answers:

Had problems paying attention when in class, doing homework,
Reading a book or playing a game? ..... Never Sometimes Often

Fidgeted or squirmed with hands or feet when you had to sit for a long
time?..... Never Sometimes Often

Felt little interest or pleasure in doing things
(Especially what you used to enjoy)?..... Never Sometimes Often

Felt down, depressed or hopeless? ..... Never Sometimes Often

Felt nervous, anxious or scared? ..... Never Sometimes Often

Not been able to stop or control worrying? ..... Never Sometimes Often

Been irritable, argued or become easily annoyed? ..... Never Sometimes Often

Disobeyed adults including those that aren't your parents? ..... Never Sometimes Often

Blamed or annoyed others? ..... Never Sometimes Often

Had thoughts about killing or hurting yourself? ..... Never Sometimes Often

Had thoughts about hurting someone else? ..... Never Sometimes Often

Been threatened or hurt by someone else? ..... Never Sometimes Often

Have you ever hurt or tried to kill yourself (in your life)? ..... Yes No Unknown

**In the last six months**, have you gambled? ..... Yes No Unknown

If yes, let us know the following:

Have you felt the need to bet more and more money?..... Yes No Unknown

Have you ever had to lie to people about how much you have gambled?..... Yes No Unknown

**In your life**, have you experienced the following? Please circle your answers.

Had an alcoholic beverage (beer, wine, liquor, etc.)?..... Yes No Unknown

Smoked or used drugs (marijuana, meth, etc.)?..... Yes No Unknown

Had any experience that was so frightening, horrible or upsetting that you:

Had nightmares or thought about it when you didn't want to?..... Yes No Unknown

Tried hard not to think about it or avoided situations

That reminded you of it?..... Yes No Unknown

Were constantly on guard, watchful or easily startled?..... Yes No Unknown

Felt numb or detached from others, activities or your surroundings? Yes No Unknown

**Please circle if you have experienced any of the following types of trauma or loss.**

| | | |
|---|---|---|
| Emotional Abuse | Neglect | Lived in a foster home |
| Sexual Abuse | Violence in the home | Multiple Family Moves |
| Physical Abuse | Crime Victim | Homelessness |
| Parent Substance Abuse | Parent Illness | Loss of a Love One |

## Medical Information

Month/Year of last physical exam: _____/_____ Pediatrician: _____

Do you have any chronic medical conditions? ..... Yes No Unknown

If yes, please list. _____

Do you have any CURRENT health concerns? ..... Yes No Unknown

If yes, please list. _____

**Current prescription medications:** [ ] None

| Medication | Dosage | Date First Prescribed | Prescribed By |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Current over-the-counter medications (including vitamins, herbal remedies, etc.):

_____

Do you have allergies and/or adverse reactions to medications?..... Yes No Unknown

If yes, please list. _____

Current grade/Placement: _____ Current School: _____

Do you have an IEP or 504? ..... Yes No Unknown
Are you having difficulties with academic performance (Grades)?..... Yes No Unknown
Are you having difficulties at school with your behavior?
(Referrals, detentions, etc.) ..... Yes No Unknown
Are you having difficulties at school with peers?..... Yes No Unknown

## Family and Developmental History

Please list the individuals in your family and their relationship to you. For children, include age.
Continue on the back of this page, if needed.

| Name | Relationship to you and quality of the relationship | Lives w/you | Age |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Have any of your family members been treated for a mental health disorder? If yes, please describe who and what disorder.

_____

During your mother's pregnancy and your birth, were there medical problems?
(Gestational diabetes, parent substance use, etc.)? ..... Yes No Unknown

Did you experience developmental delays (walking, talking, toileting, etc.)? .... Yes No Unknown
If yes to either, please describe.

_____

## Social/Cultural Information

Do you have challenges finding support (from family, friends, etc.)?..... Yes No Unknown

Are you experiencing any difficulties or concerns due to race, culture, sexual orientation, gender, gender identity, age or ethnic issues? ..... Yes No Unknown

If yes, Please describe.

_____

_____

Sexual Orientation (Optional): _____

Please list your spiritual, religious, or worldview.

_____

_____

Please list your strengths, skills, and talents.

_____

_____

List any special areas of interest or hobbies (art, books, physical fitness, etc.)

_____

_____

## Legal Information

Are your parents legally separated or divorced or were never married?..... Yes No Unknown

If yes, please describe the current custody/visitation plan.

_____

_____

Is your custody currently being reviewed or contested in court? ..... Yes No Unknown

Have you ever been a ward of the court or involved in foster care? ..... Yes No Unknown

Have you ever been charged with a legal offense or in juvenile services?..... Yes No Unknown

If yes to any of the above, please describe.

_____

_____

_____