

Hollie Wilson Counseling
2000 Highland Village Road, Suite C,
Highland Village, TX 75077
Phone: 205-238-1207
www.holliewilsoncounseling.com

ADOLESCENT INFORMATION FORM

Name		Date of First Appointment		Therapist: Hollie Wilson, LCSW-S	
Date of Birth		Age		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Name of Primary Care Physician			Physician's Phone		
Physician's Address					
Many managed care companies require that we interact with the client's physician to coordinate care. Do you give us consent to discuss your care with the above-named doctor? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Please sign here for either answer					
Date of last medical evaluation			Date of next appointment		
Name of medication		Dosage/Frequency		Start Date	Purpose
1.					
2.					
3.					
4.					
Have you ever been hospitalized for medical or psychiatric reasons? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Hospital		Month/Year		Reason	
1.					
2.					
Do you use recreational drugs? <input type="checkbox"/> YES <input type="checkbox"/> NO		If no, have you used previously? <input type="checkbox"/> YES <input type="checkbox"/> NO		If yes, when did you stop?	
Type of Drug		How Much		How Often	
1.					
2.					

3.		
Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO	If no, did you drink previously? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, when did you stop?
Type of Alcohol	How Much	How Often
1.		
2.		
Do you smoke cigarettes? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you smoke electronic cigarettes? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use other forms of tobacco? <input type="checkbox"/> YES _____ <input type="checkbox"/> NO

Describe any important medical history, chronic ailments, or other health problems you experience:
Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:
Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

Do you experience any developmental, academic, or behavior problems as a child or while in school, with peers or teachers? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please explain:
What was the most recent year of school you completed?

Please list schools currently attending, last attended, and graduated:	
Currently attending:	Year(s)
Last attended:	Year(s)
How would you describe your current support network? (friends, relatives, etc.):	
Please check all information which applies to your biological parents:	
MOTHER <input type="checkbox"/> living <input type="checkbox"/> deceased <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> remarried ___ # of times	FATHER <input type="checkbox"/> living <input type="checkbox"/> deceased <input type="checkbox"/> married <input type="checkbox"/> divorced <input type="checkbox"/> remarried ___ # of times
With whom do you live? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian <input type="checkbox"/> Grandparent	
Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, whom? _____	
Describe your relationship with your mother:	

Describe your relationship with your father:
Describe your relationship with your stepmother:
Describe your relationship with your stepfather:

List first names and ages of brothers and sisters, including yourself:			
Name	Age	Relationship (biological, step, half, etc.)	Lives with

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation

Describe any family problems which occurred while growing up relating to:

Alcohol / drug abuse:

Sexual / physical / emotional abuse:

MENTAL STATUS								
Please check any of the following that describe how you have been feeling lately:								
<input type="checkbox"/> sad	<input type="checkbox"/> anxious	<input type="checkbox"/> depressed	<input type="checkbox"/> frightened	<input type="checkbox"/> guilty	<input type="checkbox"/> angry	<input type="checkbox"/> ashamed	<input type="checkbox"/> aggressive	<input type="checkbox"/> resentful
<input type="checkbox"/> worthless	<input type="checkbox"/> tearful	<input type="checkbox"/> irritable	<input type="checkbox"/> confused	<input type="checkbox"/> extreme ups/downs	<input type="checkbox"/> jealous	<input type="checkbox"/> hopeless	<input type="checkbox"/> helpless	<input type="checkbox"/> other
Describe any other feelings you have had:								
Please check any of the following risk-taking behaviors you have engaged in:								
<input type="checkbox"/> street racing	<input type="checkbox"/> gang involvement	<input type="checkbox"/> skipping school	<input type="checkbox"/> dropped out	<input type="checkbox"/> dangerous dieting				
<input type="checkbox"/> cutting	<input type="checkbox"/> stealing	<input type="checkbox"/> unprotected sex	<input type="checkbox"/> running away	<input type="checkbox"/> bullying others				
<input type="checkbox"/> fire starting	<input type="checkbox"/> hurting animals	<input type="checkbox"/> over-exercise	<input type="checkbox"/> restricting or restricted food intake					
Please check any of the following alcohol/drugs that you currently or have previously used:								

<input type="checkbox"/> beer	<input type="checkbox"/> wine	<input type="checkbox"/> hard liquor	<input type="checkbox"/> pot	<input type="checkbox"/> cocaine	<input type="checkbox"/> heroin
<input type="checkbox"/> ecstasy	<input type="checkbox"/> speed	<input type="checkbox"/> over the counter drugs	<input type="checkbox"/> prescription drugs	<input type="checkbox"/> ice	<input type="checkbox"/> triple C's
<input type="checkbox"/> dones	<input type="checkbox"/> quad bars	<input type="checkbox"/> mushrooms	<input type="checkbox"/> benzos	<input type="checkbox"/> other:	

Have you had any change in sleeping habits? YES NO
Describe:

Have you had any change in eating habits? YES NO
Describe:

Have you ever **considered suicide** in connection to your **current** problem? YES NO
If so, please give a brief description with dates:

Have you ever **considered suicide** in the **past**? YES NO
If so, please give a brief description with dates:

Have you **attempted suicide recently** or in the **past**? YES NO
If so, please give a brief description with dates:

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? YES NO
If yes, please explain:

Have you ever **considered homicide** in the **past**? YES NO
If yes, please explain:

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social, or occupational functioning (i.e. isolation from

friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members):

What activities or hobbies do you participate in?

Do you participate in regular exercise? YES NO
Describe:

How much time do you spend online or gaming?

OTHER INFORMATION

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

THANK YOU!