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Personal History – Teen (ages 14-18)

Please provide the following information and answer the questions below. Bring the form to your first session. Information you provide here is protected as confidential information.

Client Information

Name: **Date:**

Address: ______________________________

Birth Date: ____________ **Age:** **Gender:** ☐ Male ☐ Female

Form completed by (if other than client ______________________________
Name Relationship

Home Phone: ____________ May I leave a message? ☐ Yes ☐ No

Cell Phone: ____________ May I leave a message ☐ Yes ☐ No

Email*: ____________ May I email you? ☐ Yes ☐ No

*Please note: Email correspondence is not considered a confidential form of communication.

Emergency Contact: ______________________________
Name Relationship to you

Emergency Contact Phone Number: ______________________________

Referred by (if any): ______________________________

If you need more space for any of the following questions please use the back of the sheet.

Primary reason (s) for seeking services:

____

____

____

What are your goals for your teen's therapy?

____

____

What family involvement would you like to see?

____

____

Family History

Parents:

With whom does the teen live at this time? ______________________________

Are parents: ☐ Never Married ☐ Domestic Partners ☐ Married ☐ Separated

☐ Divorced ☐ Widowed

If divorced or separated, who has legal custody? ______________________________

If divorced, has either parent remarried? ☐ Yes ☐ No

Mother Remarried ☐ Date: ____________ Spouse's Name: ______________________

Father Remarried ☐ Date: ____________ Spouse's Name: ______________________

Client's Mother

Name: ______________________ Age: ______ Occupation : ______________________

Where Employed ______________________ Work Phone ______________________

Mother's Education ______________________________

Does teen currently live with mother? ☐ Yes ☐ No

☐ Natural Parent ☐ Step Parent ☐ Adoptive Parent

☐ Other (Specify): ______________________________

Anything notable or stressful about teen's relationship with mother?

____

____

Client's Father

Name: ______________________ Age: ______ Occupation : ______________________

Where Employed ______________________ Work Phone ______________________

Father's Education ______________________

Does teen currently live with father? ☐ Yes ☐ No

☐ Natural Parent ☐ Step Parent ☐ Adoptive Parent

☐ Other (Specify): ______________________

Anything notable or stressful about teen's relationship with father?

____

____

Siblings

Name	Age	Gender	Lives	Relationship Quality
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M	☐ Home ☐ Away	☐ Poor ☐ Avg ☐ Good

Others Living in Household

Name	Age	Gender	Relationship	Relationship Quality
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good
		☐ F ☐ M		☐ Poor ☐ Avg ☐ Good

Who handles responsibilities for your teen in the following areas:

School ☐ Mother ☐ Father ☐ Shared ☐ Other: ______________________

Health ☐ Mother ☐ Father ☐ Shared ☐ Other: ______________________

Problem Behavior ☐ Mother ☐ Father ☐ Shared ☐ Other: ______________________

Family Mental Health History

Is there a family history of any of the following? If yes, please indicate the family member's relationship to the client in the space provided.

Example:

Issue	Response	Relationship to Client
Anxiety	X Yes ☐ No	Maternal Grandmother and Mother

Issue	Response	Relationship to Client
ADHD	☐ Yes ☐ No	
Alcohol/Substance Abuse	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Domestic Violence	☐ Yes ☐ No	
Eating Disorders	☐ Yes ☐ No	
Obsessive Compulsive Behavior	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Suicide Attempts	☐ Yes ☐ No	

Early Development History

Any problems with child during pregnancy? ☐ Yes ☐ No

If **yes**, please explain:

Was pregnancy planned? ☐ Yes ☐ No

Mother's age at birth Father's age at birth

Type of delivery: ☐ Vaginal ☐ Cesarean-Section

Did mother smoke while pregnant? ☐ Yes ☐ No If yes, how much?

Did mother use drugs or alcohol? ☐ Yes ☐ No If yes, type/amount

While pregnant did mother have any medical or emotional difficulties? ☐ Yes ☐ No

If yes, please explain ______________________________

Any problems with child's birth or immediately after?? ☐ Yes ☐ No

If yes, please explain ____________________

Please describe your child before the age of 2 (i.e., calm, active, difficult, fearful, sad, happy, etc.

____

____

Was it an easy or difficult attachment? ____________________

Compared with others in the family, the child's/teen's development was:

☐ Slow ☐ Average ☐ Fast

Age for following developments:

Began puberty	____________	Menstruation	____________
Voice change	____________	Injuries/Hospitalized	____________

Education

Grade in School ____________________

School of Attendance ____________________

Type of school ☐ Public ☐ Private ☐ Home-schooled

What subjects does your teen enjoy in school? ____________________

What subjects does your teen enjoy in school ____________________

What grades does your teen usually receive in school ____________________

Have there been any recent changes in your teen's grades? ☐ Yes ☐ No

Does your teen receive Special Education Services? ☐ Yes ☐ No

If yes, please explain ____________________

____

Check the descriptions that specifically relate to your teen:

Feelings about school work:

☐	Anxious	☐	Passive	☐	Enthusiastic	☐	Fearful
☐	Eager	☐	No Expression	☐	Bored	☐	Rebellious
☐	Other						

Approach to school work:

☐	Organized	☐	Industrious	☐	Responsible	☐	Interested
☐	Self-directed	☐	No Initiative	☐	Refuses	☐	Does only what's expected
☐	Sloppy	☐	Disorganized	☐	Cooperative	☐	Doesn't do assignments

Performance in school (Parent's opinion):

☐	Satisfactory	☐	Responsible	☐	Underachiever	☐	Overachiever
☐	Other						

Peer relationships:

☐	Spontaneous	☐	Makes friends easily	☐	Has long time friends	☐	Shares easily
☐	Difficulty making friends	☐	Follower	☐	Leader		
☐	Other						

How many friends does your teen have at school? ______________________

How much time do they hang out per week? ______________________

How many friends does your teen have at home/through other activities? ______________________

How much time do they hang out per week? ______________________

Medical/Physical History

Pediatrician's Name ______________________

Date of teen's last medical exam ______________________

Does your teen wear glasses? ☐ Yes ☐ No

Has your teen ever been hospitalized? ☐ Yes ☐ No

If yes, please explain ______________________

Has your teen ever had a fever over 104 degrees? ☐ Yes ☐ No

If yes, please explain ______________________

Has your teen ever had any accidents or serious injuries? ☐ Yes ☐ No

If yes, please explain ______________________

Does your teen have asthma/allergies? ☐ Yes ☐ No

If yes, please explain ______________________

Any other health concerns? ______________________

____

Describe your teen's eating habits:

Meal	# Times/Week	Typical Foods Eaten	Amount typically Eaten
Breakfast	___ /week	______	☐ Doesn't eat ☐ Low ☐ Med ☐ High
Lunch	___ /week	______	☐ Doesn't eat ☐ Low ☐ Med ☐ High
Dinner	___ /week	______	☐ Doesn't eat ☐ Low ☐ Med ☐ High
Snacks	___ /week	______	☐ Doesn't eat ☐ Low ☐ Med ☐ High

Currently prescribed medications:

Dose	Dates	Purpose	Side effects

Over the counter medications currently taken:

Dose	Dates	Purpose	Side effects

Does your teen use or have any issues with alcohol or drugs? ☐ Yes ☐ No

If yes, please explain ______________________________

Does your teen receive any other counseling? ☐ Yes ☐ No

If yes, with whom? ______________________________

Leisure/Recreational

Describe hobbies or special interests your child might have (art, reading, crafts, fitness, sports, camping, dance, school activities, Scouts etc.)

____

____

____

What are the family's favorite activities? ______________________________

____

How does your child/teen spend unstructured time??

____

____

Behavioral/Emotional

Please check any of the following that are typical for your child/teen:

- ☐ Affectionate
- ☐ Aggressive
- ☐ Angry
- ☐ Avoids adults
- ☐ Bedwetting
- ☐ Blinking/jerking
- ☐ Bizarre behavior
- ☐ Bullies, threatens
- ☐ Careless, reckless
- ☐ Chest pains
- ☐ Clumsy
- ☐ Confident
- ☐ Cooperative
- ☐ Cyber addiction
- ☐ Defiant
- ☐ Depressed
- ☐ Destructive
- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Eating issues
- ☐ Enthusiastic
- ☐ Expects failure
- ☐ Fatigue
- ☐ Fearful
- ☐ Frequent injuries
- ☐ Frustrated easily
- ☐ Generous
- ☐ Hallucinations
- ☐ Head-banging
- ☐ Hopelessness
- ☐ Hurts animals
- ☐ Imaginary friends
- ☐ Impulsive
- ☐ Irritable
- ☐ Lazy
- ☐ Learning problems
- ☐ Lies frequently
- ☐ Listens to reason
- ☐ Loner
- ☐ Low self-esteem
- ☐ Messy
- ☐ Nightmares
- ☐ Obedient
- ☐ Often sick
- ☐ Oppositional
- ☐ Overweight
- ☐ Panic attacks
- ☐ Phobias
- ☐ Psychiatric problems
- ☐ Quarrels
- ☐ Sad
- ☐ Selfish
- ☐ Separation anxiety
- ☐ Sets fires
- ☐ Sexual acting out
- ☐ Shares
- ☐ Short attention span
- ☐ Shy, timid
- ☐ Sleeping problems
- ☐ Slow moving
- ☐ Soiling
- ☐ Speech problems
- ☐ Steals
- ☐ Stomach aches
- ☐ Suicidal threats
- ☐ Suicide attempts
- ☐ Talks back
- ☐ Teeth grinding
- ☐ Thumb sucking
- ☐ Tics or twitching
- ☐ Unsafe behaviors
- ☐ Unusual thinking
- ☐ Weight loss
- ☐ Withdrawn
- ☐ Worries Excessively

Please describe any of the above or any other concerns. Use the back of the page if more space is needed

Was there a clear time when behaviors became worse? ☐ Yes ☐ No

If yes, please describe

How often does the behavior(s) occur?

How are problems usually handled?

Additional Information

What major stressors have occurred in your teen's lifetime? (i.e., death, illness, divorce, domestic violence, abuse, addiction, moving)

List your teen's strengths

List the three biggest stressors in your teen's life currently

Any additional information about your child/teen that you would like to share/feel is relevant?

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___

___