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Adolescent History Form

Today's Date: ______________________

Client Name: ____

Date of Birth: ________________ Age: ____________ Ethnicity: ______________________

Gender: ___Male ___Female ___Other (describe): ________________________________

Client's Address: ____

City: ______________________________________ State: _________ Zip: _________________

Client's Phone Numbers:	**Okay to Call**	**Text**	**Leave Message**
Cell __________________________	Y / N	Y / N	Y / N
Home ________________________	Y / N	Y / N	Y / N

Client's Email: ____ Okay to Send Email? Y / N

Mother's Name: _________________________________ **Age:** ____ **Date of Birth:**___________

Mother's Address:

____

City: ____ State: _________ Zip:______________

Mother's Phone Numbers:	**Okay to Call**	**Text**	**Leave Message**
Cell: ___________________________	Y / N	Y / N	Y / N
Home: _________________________	Y / N	Y / N	Y / N
Work: _________________________	Y / N	Y / N	Y / N

Mother's Email: ____ Okay to send email: Y / N

Mother's Marital Status (circle): Single Married Partnered Other: ___________________

Name of Mother's Spouse or Partner: ____

Father's Name: _________________________________ Age: _____ Date of Birth:___________

Father's Address:

____

City: ____ State: _________ Zip:______________

Father's Phone Numbers:	**Okay to Call**	**Text**	**Leave Message**
Cell ___________________________	Y / N	Y / N	Y / N
Home _________________________	Y / N	Y / N	Y / N
Work: _________________________	Y / N	Y / N	Y / N

Father's Email: ____ Okay to send email: Y / N

Father's Marital Status (circle): Single Married Partnered Other: ___________________

Name of Father's Spouse or Partner: ____

If parents are separated or divorced, please describe custody arrangements:

____

____

Please list siblings, step-parents, and others living in each household:

____

____

____

____

Emergency Contact Name/Phone Number: ____

Religion (optional): ____

Current Grade: ______________ School Attending:___________________________________

IEP or 504 Plan? Y / N If Yes, Describe:____

Current Place of Employment: ____

Reason for Seeking Therapy:

____

____

____

____

Please check your concerns regarding your adolescent over the last 30 days:

- □ Feelings of Depression
- □ Mood Swings
- □ High Anxiety
- □ Panic Symptoms
- □ Frequent Worry
- □ Excessive Stress
- □ School or Work-Related Concerns
- □ Social Withdrawal
- □ Low Motivation/Energy
- □ Irritability
- □ Thoughts of Suicide
- □ Self-Harm
- □ Racing Thoughts
- □ Compulsive Thoughts or Behaviors
- □ Hearing Voices or Seeing Visions
- □ Feelings of Paranoia
- □ Risky Behaviors, please specify: ______________________________
- □ Anger
- □ Aggressive Behavior
- □ Substance Use
- □ Difficulty with Concentration
- □ Difficulty with Attention
- □ Distractibility
- □ Hyperactivity
- □ Sleep Problems
- □ Poor Appetite
- □ Running Away
- □ Truancy
- □ Oppositional Behavior
- □ Memory Problems
- □ Excessive Energy
- □ Abuse or Trauma
- □ Sexual Assault
- □ Relationship Problems, specify with whom: ______________________

Please describe any health concerns your adolescent has:
____

____

Please list all medications your adolescent is currently taking:

Name of Medication	Dose	When Started	Prescribed By

Has your adolescent previously seen a mental health provider? Y / N

Has your adolescent ever been psychiatrically hospitalized? Y / N

If Yes, please list:

Name	Dates Seen	Reason	Helpful Y / N

Has you adolescent ever been treated for substance use? Y / N

If Yes, please describe: ____

Has your adolescent had any legal Involvement? Y / N

If Yes, please describe: ____

Developmental History

Please list approximate age your child met each developmental milestone:

Sat Alone: First Word:

Crawled: Spoke in Sentences:

Walked: Toilet Trained:

Any Concerns about your adolescent's development as an infant/toddler:

____

____

Please list any specific questions or concerns you would like addressed during your first visit:

____

____

____

____

____

____

Thank you for taking the time to complete this form!

____ __________________

Parent/Guardian Signature Date

____ __________________

Angela C. Stanley, Psy.D. Date