

ADOLESCENT INFORMATION SHEET

Date: _____

Name: _____ Age: _____

Date of Birth: _____ Ethnicity/Race: _____

Address: _____ City, State, Zip: _____

Phone: _____

School: _____ Grade: _____

How were you referred to this agency? _____

In your own words, what are the reasons for your seeking counseling? What have the problems been? What are you hoping to accomplish through counseling?

Have you or your family ever been involved in counseling? Yes No

If yes, when and where? _____

Have you ever been arrested or charged with any unlawful activity? Yes No

Family Information

Who do you live with?

- Mother Step-Mother Guardian
 Father Step-Father Other: _____

Do you have a job? Yes No Where: _____ Hours/Week _____

Father's Occupation: _____

Mother's Occupation: _____

Names and ages of brothers and sisters (circle that one who are presently living with you)

BROTHERS	AGE	SISTERS	AGE

Do you experience medical problems at the present time? Yes No

Explain: _____

Are you taking any prescribed medication? Yes No

Explain: _____

Use of Alcohol

Do you drink alcohol? Yes No

What do you generally drink the most? _____

How old were you when you started drinking? _____

How many times per week do you:

Drink	0	1	2	3	4	5	Over 5 Times Per Week
Get Drunk	0	1	2	3	4	5	Over 5 Times Per Week

Do you feel that you are drinking **more, less or the same** as you were a year ago? _____

Use of Marijuana

When did you start smoking pot? _____

How many times per week do you smoke pot?

0 1 2 3 4 5 6 7 8 9 Over 9 Times per Week

Is it **harder or easier** to get high on pot than it used to be? _____

Do you feel that you are getting high **more, less or the same** as you were one year ago? _____

Use of Other Drugs

Do you smoke cigarettes? Yes No

How many packs per day do you smoke? _____

Check the drugs you have tried more than once:

Cocaine	Speed	Heroin	Barbituates/Downers
Tranquilizers	Opium	Valium	Hash
Angel Dust	Glue	Rush	Mescaline
Codeine	LSD/Acid	Amphetamines/Uppers	Gasoline

School Information

How well do you like school? I don't like it I like it I sort of like it

How many classes do you skip each week? 1 2 3 4 5 Over 5

My grades are usually: A's B's C's D's F's

How many referrals did you get last semester? _____

How many referrals did you get last year? _____

Home

Who do you fight with the most? (check one or more)

Mother Sister(s) Friends
 Father Brother(s) Other

Who do you usually get along with?

Mother Sister(s) Friends
 Father Brother(s) Other

Do your parents like your friends? Yes No

Have you ever run away from home? Yes No

Are you planning to run soon? Yes No

Things About Myself

Do you feel you get depressed/very sad a lot? Yes No

If yes, have you ever thought of committing suicide? Yes No

If yes, have you ever attempted suicide? Yes No

Check any of the following that you feel may apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Over ambitious |
| <input type="checkbox"/> No appetite | <input type="checkbox"/> Can't make friends |
| <input type="checkbox"/> Tired often | <input type="checkbox"/> Feel lonely |
| <input type="checkbox"/> Can't sleep | <input type="checkbox"/> Can't make decisions |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Weight loss or weight gain |
| <input type="checkbox"/> Feel tense | <input type="checkbox"/> Temper problems |
| <input type="checkbox"/> Feel panicky | <input type="checkbox"/> Stomach trouble |
| <input type="checkbox"/> Unable to have a good time | <input type="checkbox"/> No self confidence |
| <input type="checkbox"/> Unable to relax | <input type="checkbox"/> Interrupted sleep |

What do you enjoy doing (i.e. hobbies, skills, activities)? _____

Rate Yourself

On a scale of 1 to 10, how do you feel about yourself?

(I don't like myself) 1 2 3 4 5 6 7 8 9 10 (I like myself)

Please check the statements that apply to you:

	<u>Yes</u>	<u>Sometimes</u>	<u>Not Certain</u>	<u>No</u>
1. People seem to be against me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I feel like I'm going crazy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I feel I do things that I cannot understand later	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I have lost interest in things that were once very important to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I don't want to be around people anymore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I get angry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I lose my temper a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Much of the time I feel like just giving up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I see things which I'm not sure are really there	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I have problems with my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I have trouble getting people to understand what I'm thinking or feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I feel I'm taken for granted or that other people don't respect me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. The same thoughts run through my head over and over again	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I have a hard time expressing my feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I am pretty good at seeing other people's points of view	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I see myself or others see me as irresponsible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I usually feel guilty when I have done something wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I can't stop doing things wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Being a delinquent is no big deal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I have problems with my parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I get angry at others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. My parents don't understand me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I have problems with my brother/sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I am intelligent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I can talk about important matters with my parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I need more freedom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. My parents are too strict	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. My parents are not strict enough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I believe I have emotional problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. I believe I have a problem with alcohol/drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. I can solve my own problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. My teachers are the problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. My parents are the problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. I would like to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. I would quit school if I could	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Life is worth living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>