
Confidential Information Sheet - Teen

(to be filled out by teen)

Name: _____ Today's Date: _____

Address: _____

Phone (C): _____ OK to leave message? Y / N

Phone (H): _____ OK to leave message? Y / N

Email: _____ OK to use? Y / N (note: email is not secure)

School: _____ Grade: _____ Job: _____

Date of Birth _____ About how long since last Medical Check-Up: _____

Ethnicity: _____ Religion / Spirituality (if any): _____

Whose idea was it for you to come here? Mine Parents Other

If someone else, are you OK with this idea? Yes No Not Sure

Main reason(s) for seeking help: _____

How long ago did this start? _____

What have you tried? _____

FAMILY

With whom do you live? _____

How often do you see your father? daily / weekly / monthly / once a year / never

How often do you see your mother? daily / weekly / monthly / once a year / never

Describe your family:	Mother	Father	Step-mother	Step-father	Brother	Sister	Other
Likes me							
Kind							
Pleasant							
Understanding							
Easygoing							
Rarely home							
Strict							
Mean							
Critical							
Negative							
Angry							
Uses drugs							
Uses alcohol							
Verbally abusive							
Physically abusive							

Kind of punishment - indicate who:

	Mother	Father	Step-mother	Step-father	Other
Sends you to your room					
Takes away privileges					
Restricts or grounds you					
Spanks / hits					
Other					

MEDICAL

Do you have or have you had any major medical problems or been hospitalized? Yes No

If so, please list: _____

Are you on any medications (including birth control pills)? Yes No

If so, please list: _____

Are you, or have you been, sexually active? Yes No

Do you practice safe sex? Yes No

What is your sexual orientation? _____

For females: Have you stated your period? No Yes At what age? ____

Are you pregnant? Yes No

Have you ever been pregnant? Yes No

Have you ever drank alcohol? Yes No How often? _____

Do you smoke or use tobacco? Yes No

Do you use drugs? No Yes If so, what kind? _____

Do you think your drug or alcohol use is a problem? Yes No

PROBLEMS / SYMPTOMS

Please check off any items that apply to you:

Now	Past		Now	Past		Now	Past	
___	___	Restless	___	___	Sexual Problems	___	___	Memory problems
___	___	Act without thinking	___	___	Problems with the law	___	___	Hard to make decisions
___	___	Enjoy 'bugging' people	___	___	Fire-setting	___	___	Irritable / angry
___	___	Low motivation	___	___	Hurt people	___	___	Withdrawn from others
___	___	Easily frustrated	___	___	Very anxious	___	___	Trouble concentrating
___	___	Daydream or fantasize a lot	___	___	Worry more than others	___	___	Sadness, crying or depression
___	___	Temper outbursts	___	___	Fearful	___	___	Nothing fun any more
___	___	Back talk / Argue a lot	___	___	Nervous / can't relax	___	___	Low self-esteem
___	___	Hard to admit mistakes	___	___	Damaged property	___	___	Sleep problems
___	___	Difficulty paying attention	___	___	Want to run away from home	___	___	Have run away from home
___	___	Repeat an unnecessary act over and over	___	___	Eat little or fast to lose weight	___	___	Nightmares, night terrors
___	___	Hurt animals	___	___	Sneak out at night	___	___	Binge on food
___	___	Stolen things	___	___	Tired, fatigued	___	___	Attempted suicide
___	___	Hear voices or see things that aren't there	___	___	Vomit food on purpose	___	___	Too worried about germs, safety, health
___	___	Other: _____						

Check the boxes that describe your relationships with others:

- Prefer to be alone
- Alone a lot, but feel lonely
- Problem getting along with others
- Shy
- Hard to get along with siblings
- Conflict with my parents or step-parents
- Family member drinks too much
- Family member uses drugs
- Family member, relative, or friend tried to kill him/herself
- I have a best friend
- I have a lot of friends
- I go out with friends. Where to? _____
- I have a steady boyfriend or girlfriend. Their age? _____
- Being physically or sexually abused
- Being neglected
- Getting picked on a lot by peers
- Getting picked on a lot by family member

I have had these problems at school:

- Difficulties with classmates
- Not having friends at school
- Not getting along with teachers
- Cutting school or class a lot
- Poor grades
- Learning problems
- Detention or Saturday school
- Been suspended (How many times? _____)
- Been expelled (How many times? _____)
- Getting in fights at school

Have you had any of the following experiences or problems, now or in the past?

	None or a little of the time	Some of the time	Good part of the time	Most of all of the time
It feels too painful to keep on living				
I feel my family would be better off if I were dead				
I think about suicide				
I have thought of how to kill myself				
In order to punish others, I think of suicide				

LEGAL

Have you ever been involved with the police or court? Check one:

- No Yes, in the past month Yes, in the past 6 months Yes, over 6 months ago

Do you see a social worker or probation officer regularly? No Yes

If so, what is their name and phone number? _____

OTHER

What happened *now* that got you to seek help? _____

Who else is helping you with this problem? _____

Have you ever seen a counselor or therapist in the past? Yes No

If so, when? _____ Whom did you see? _____

For what? _____ Was it helpful? Yes No

If so, how? _____

Is there anything else I should know that might be important?

Thank you.