Achieving Family Wellness, LLC

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Client Information Form ADOLESCENT

Today's Date: ***How did you hear about us?***

Personal information

First Name: MI:	Last Name:
Birthdate: Age:	☐ Male ☐ Female

Address: City: State: Zip:

To protect your confidentiality, any mail (including billing statements) sent to the above address will arrive in a discrete envelope listing only the office's return address.

Contact Information

Home Phone #	☐I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number.
Mobile #	☐ I give permission to leave a message at this number ☐ I DO NOT give permission to leave a message at this number.
Email:	☐ I give permission be contacted by email (email may not be confidential)

What is your preferred method of contact? (mark only one): ☐ Home Phone ☐ Mobile Phone ☐ Email

Parent/Guardian Information

Relationship Status: ☐ single ☐ married ☐ co-habitating ☐ separated ☐ divorced ☐ widowed ☐ engaged

Father: Address: Phone:

Mother Address: Phone:

Step-Father: Involved in counseling? ☐ Yes ☐ No

Step-Mother Involved in counseling? ☐ Yes ☐ No

Emergency Contact Information

Name:	Relationship:
Home Phone:	Mobile:

Insurance Information

Medicaid: ☐Yes ☐No Medicaid Number: Medicaid your ONLY insurance provider? ☐Yes ☐No

Insurance Provider: Employer:

Policy Number/Member ID: Group Number:

Policy Holder's Name: DOB: ☐M ☐F

Policy Holder's Address: Phone Number:

Client's Relationship to Policy Holder: ☐self ☐spouse ☐child ☐other

Employee Assistant Program Provider: Authorization: # of Visits:

Other Payment

☐Out of Pocket/Self-Pay ☐Sliding Scale/Intern Fee:

Adolescent Clinical History Form

Symptoms Screener

For the questions below, select one option for each question that comes closest to your answer.

OVER THE PAST *TWO WEEKS*, HAVE YOU:	**Not At All**	**1-2 Days**	**3-5 Days**	**Daily**
Experienced sadness, weepiness, or crying spells.	☐	☐	☐	☐
Felt hopeless, pessimistic or discouraged about the future.	☐	☐	☐	☐
Not been able to enjoy things?	☐	☐	☐	☐
Felt tired, slowed down, or had no energy?	☐	☐	☐	☐
Lacked motivation or interest in doing things?	☐	☐	☐	☐
Had difficulty falling asleep or frequent waking/sleeping too much?	☐	☐	☐	☐
Had difficulty making decisions or concentrating?	☐	☐	☐	☐
Experienced decreased/decreased appetite?	☐	☐	☐	☐
Felt guilty or worthless?	☐	☐	☐	☐
Felt like you wanted to die, or wished you were dead?	☐	☐	☐	☐
Seriously considered or planned to end your own life?	☐	☐	☐	☐
Felt restless, worried, or nervous?	☐	☐	☐	☐
Had headaches, stomachaches or pain?	☐	☐	☐	☐
How much distress would you say these symptoms caused you?		☐ **Mild**	☐ **Moderate**	☐ **Severe**

IN YOUR LIFETIME HAVE YOU EVER HAD A *WEEK* WHERE YOU:	**Yes**	**No**
Felt excessive energy to the point of being hyper, overexcited, or giddy?	☐	☐
Had an unusually high or good mood that was uncharacteristic of you?	☐	☐
Felt like your mind was flooded with ideas and your thoughts were racing?	☐	☐
Did not need as much sleep as you normally do?	☐	☐
Acted impulsively by participating in risky or irresponsible behavior (increased shopping, sex, drugs, alcohol)?	☐	☐
Felt more interest in exciting, pleasurable activities than you usually do?	☐	☐
Felt more outgoing, rowdy, or socially open than you regularly do?	☐	☐
Found yourself easily distracted by things going on around you?	☐	☐

DURING THE PAST SIX *MONTHS* HAVE YOU EXPERIENCED THE FOLLOWING *THREE OR MORE* TIMES PER WEEK?	**Yes**	**No**
Felt nervous and anxious about things at work, home, or school?	☐	☐
Had difficulty controlling worries or fears?	☐	☐
Felt restless, nervous, or on edge?	☐	☐
Felt tired, exhausted, or easily worn out?	☐	☐
Had difficulty concentrating?	☐	☐
Felt easily annoyed, irritated or frustrated?	☐	☐
Had difficulty with tense or tight muscles?	☐	☐
Had trouble falling asleep or woke frequently throughout the night?	☐	☐
Had others notice that you worry or been told that you worry too much?	☐	☐
How much distress would you say these symptoms cause you? ☐ **Mild** ☐ **Mild-Moderate** ☐ **Moderate** ☐ **Moderate-Severe**		

HAVE YOU EVER EXPERIENCED A MOMENT IN TIME WHEN YOU FELT INTENSE FEAR AND DISTRESS AND EXPERIENCED AT LEAST THREE OF THE FOLLOWING SYMPTOMS?	Yes	No
Shaking or trembling?	☐	☐
Intense sweating?	☐	☐
Loss of breath or shallow breathing?	☐	☐
Feeling dizzy or out of control?	☐	☐
Rapid heartbeat?	☐	☐
Nausea?	☐	☐
Fear of dying?	☐	☐

How much distress would you say these experiences caused you? ☐ **Mild** ☐ **Mild-Moderate** ☐ **Moderate** ☐ **Moderate-Severe**

HAVE YOU EVER EXPERIENCED OR WITNESSED ANY OF THE FOLLOWING TRAUMATIC EVENTS?	Yes	No
Natural disaster (flood, hurricane, tornado, earthquake, fire, industrial accident?	☐	☐
Transportation accident (car, boat, train, or plane)?	☐	☐
Physical assault as a child?	☐	☐
Physical assault as an adult?	☐	☐
Sexual assault/abuse as a child?	☐	☐
Sexual assault as an adult?	☐	☐
Combat, exposure to a war-zone, or captivity?	☐	☐
Life threatening illness?	☐	☐
Sudden, unexpected death or injury of someone close to you?	☐	☐
Serious injury, harm, or death to someone else you caused or witnessed?	☐	☐
Experienced re-occurring and unwanted flashbacks, nightmares or reminders of the event?	☐	☐
Made efforts to avoid thinking or talking about this event, or doing thing that remind you of it?	☐	☐
Felt less interest in people and things, a feeling of numbness, or trouble experiencing emotions?	☐	☐
Felt nervous, jumpy, or had a sense of heightened alertness?	☐	☐
Had trouble with irritability, falling or staying asleep, or with concentrating?	☐	☐

IN THE LAST MONTH HAVE YOU?	Yes	No
Avoided touching certain things because of possible contamination?	☐	☐
Had difficulty picking up items that have dropped on the floor?	☐	☐
Cleaned your household excessively?	☐	☐
Often taken extremely long showers or baths (more than 1 per day)?	☐	☐
Been overly concerned with germs and diseases?	☐	☐
Frequently had to check things over and over again?	☐	☐
Had difficulty finishing things because you repeat actions?	☐	☐
Repeated actions in order to prevent something bad from happening?	☐	☐
Worried excessively about making mistakes?	☐	☐
Worried excessively that someone will get harmed because of you?	☐	☐
Experienced thoughts that come into your mind making you do things over and over again?	☐	☐
Needed have certain things around you set in a specific order?	☐	☐
Spent a significant amount of time making sure that things are in the right place?	☐	☐
Noticed immediately when your things are out of place?	☐	☐
Needed to arrange certain things in special patterns?	☐	☐
Had difficulty throwing things away?	☐	☐
Find yourself bringing home seemingly useless materials?	☐	☐
Over the years your home has become cluttered with collections?	☐	☐
Not liked other people to touch your possessions?	☐	☐
Often had to say certain things to yourself again and again in order to feel safe?	☐	☐
Found that "bad" thoughts force you to think about "good" thoughts	☐	☐
Try to remember events in detail or make mental lists to prevent unpleasant consequences?	☐	☐

HAVE YOU EVER:	Yes	No
Do you often feel that you can't control what or how much you eat?	☐	☐
Do you often eat, within a 2 hours period, what most people would regard as an unusually large amount of food?	☐	☐
Has it been as often, on average, as twice a week for the last three months?	☐	☐
In the last three months have you often done any of the following in order to avoid gaining weight?	☐	☐
1. Made yourself vomit?	☐	☐
2. Took more than twice the recommended dose of laxatives?	☐	☐
3. Fasted, not eaten anything at all, for at least 24 hours.	☐	☐
4. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐
If you checked "yes" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

HISTORY OF RECREATIONAL DRUG USE

Amphetamines/Speed	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Barbiturates	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Heroin	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Narcotics (Vicodin, Oxy)	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Cocaine	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
LSD, Ecstasy, Bath Salts	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Cannabis/Marijuana	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Benzodiazepines	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
PCP	☐Yes	☐No	Age of First Use:	Age of last use:	Method:
Adderall (non-prescribed)	☐Yes	☐No	Age of First Use:	Age of last use:	Method:

	Yes	No
In the past twelve months have you used drugs for other than medical reasons?	☐	☐
Have you ever experienced withdrawal symptoms when you stopped taking drugs?	☐	☐

ALCOHOL CONSUMPTION	Yes	No
Do you regularly drink alcohol (including beer or wine?)	☐	☐
How often to you typically drink: **never**---**rarely** (2x per month or less)----**often** (weekly) ---- **frequently** (2-3x per week)---**daily**		
How often to you drink until the point of intoxication? **never**--- **rarely** (2x per month or less)---**often** (weekly) ---**frequently** (2-3x per week)---**daily**		
Has your drinking ever caused problems between you and family members or close relationships?	☐	☐
Have you tried to cut back or stop drinking, but have not been successful?	☐	☐
Have you drank alcohol, and were hung over while working, going to school, or taking care of children?	☐	☐
You missed, or where late, for work, school, or other activities because you were drunk or hung over?	☐	☐
Been in trouble with the law because of drinking?	☐	☐
Have you ever experienced withdrawal symptoms when you stopped drinking?	☐	☐

OTHER SUBSTANCES

Do you smoke?	☐ **Yes** ☐ **No**	How many per day?
Do you drink caffeinated beverages?	☐ **Yes** ☐ **No**	How many per day?

SELF-HARM

Have you ever cut yourself or hurt yourself intentionally: ☐ **Yes** ☐ **No** **If Yes, Describe:**

Additional Symptoms

	Never	Occasionally	Often	Very Often
Does not pay attention to details or makes careless mistakes with for example, homework?	☐	☐	☐	☐
Has difficulty keeping attention to what needs to be done.	☐	☐	☐	☐
Does not seem to listen when spoken to directly.	☐	☐	☐	☐
Does not follow through when given directions and fails to finish activities.	☐	☐	☐	☐
Avoids, dislikes, or does not want to start tasks that require ongoing mental effort.	☐	☐	☐	☐
Loses things necessary for tasks or activities (toys, assignments, pencils, books).	☐	☐	☐	☐
Is easily distracted by noise or other stimuli	☐	☐	☐	☐
Is forgetful in daily activities.	☐	☐	☐	☐

	Excellent	Above Average	Average	Some Problems	Problematic
Overall school performance.	☐	☐	☐	☐	☐
Reading.	☐	☐	☐	☐	☐
Writing.	☐	☐	☐	☐	☐
Mathematics.	☐	☐	☐	☐	☐
Relationship with parents.	☐	☐	☐	☐	☐
Relationship with siblings.	☐	☐	☐	☐	☐
Relationship with peers.	☐	☐	☐	☐	☐
Participation in organized activities (teams).	☐	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
Fidgets with hands or feet or squirms in seat.	☐	☐	☐	☐
Leaves seat when remaining seated is expected.	☐	☐	☐	☐
Runs or climbs too much when being seated is expected.	☐	☐	☐	☐
Has difficulty playing, or beginning quiet activities.	☐	☐	☐	☐
Is “on the go” or acts as “driven by a motor.”	☐	☐	☐	☐
Talks too much.	☐	☐	☐	☐
Blurts out answers before questions have been completed.	☐	☐	☐	☐
Has difficulty waiting his or her turn.	☐	☐	☐	☐
Interrupts or intrudes in on conversations or activities.	☐	☐	☐	☐
Is perceived as annoying or irritating.	☐	☐	☐	☐
Engages in negative attention seeking behaviors.	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
Argues with adults.	☐	☐	☐	☐
Loses temper.	☐	☐	☐	☐
Actively defies or refuses to go along with adults’ requests or rules.	☐	☐	☐	☐
Deliberately annoys people.	☐	☐	☐	☐
Is touchy or easily annoyed by others.	☐	☐	☐	☐
Is angry or resentful.	☐	☐	☐	☐
Is spiteful and wants to get even.	☐	☐	☐	☐

	Never	Occasionally	Often	Very Often
Bullies, threatens or intimidates others.	☐	☐	☐	☐
Starts physical fights.	☐	☐	☐	☐
Lies to get out of trouble or to avoid obligations (i.e., "cons others).	☐	☐	☐	☐
Skips school.	☐	☐	☐	☐
Is physically cruel to people.	☐	☐	☐	☐
Has stolen things that have value.	☐	☐	☐	☐
Deliberately destroys other's property.	☐	☐	☐	☐
Has used a weapon that can cause serious harm (bat, knife, gun).	☐	☐	☐	☐
Is physically cruel to animals.	☐	☐	☐	☐
Has deliberately set fires to cause damage.	☐	☐	☐	☐
Has broken into someone else's home, business, or car.	☐	☐	☐	☐
Has stayed out at night without permission.	☐	☐	☐	☐
Has run away from home overnight.	☐	☐	☐	☐
Has forced someone into sexual activity.	☐	☐	☐	☐

Current Concerns

BRIEFLY DESCRIBE THE REASON(S) YOU ARE SEEKING COUNSELING:

About how long have you been concerned about this: ☐ 1 month ☐ 2-3 months ☐ 6 months ☐ 1 year ☐ Other:

DOES IT CAUSE PROBLEMS/STRESS IN ANY OF THE CATEGORIES BELOW?

	None	Mild Stress	Moderate Stress	Severe Stress
Health (include sleep and appetite)	☐	☐	☐	☐
Education/Employment	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Day to day tasks/chores	☐	☐	☐	☐
Finances	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Family/Significant Relationships	☐	☐	☐	☐
Legal System	☐	☐	☐	☐

Describe anything marked other than NONE:

Social Functioning

WHICH BEST DESCRIBES YOUR CHILD'S SOCIAL SITUATION?

☐ Supportive social network/friends ☐Makes friends easily ☐Feels lonely/isolated ☐Few friends

☐ Conflict with peers/classmates ☐Gets bullied ☐Difficult sustaining friendships ☐No friends

☐ Other/Describe:

SEXUAL ACTIVITY HISTORY:

Is Client sexual active? ☐ **Yes** ☐ **No**

☐ Age became sexually active:

☐ Number of sexual partners:

☐ Method of birth control:

☐ Pregnancies

☐ Abortions

Family History

Has your child ever experienced parental separation, divorce, or death? ☐ Y ☐N How old was child?

If the parents are separated or divorced, who has custody? ☐ Mother ☐ Father ☐ Joint ☐ Other:

Please describe current custody/legal or foster child arrangements for this child:

Describe child's current family environment: who lives in the home, strengths/stressors, dynamics:

Please list child's siblings (including step-siblings):

Name	Age	M/F	Living in the Home?
			☐ Y ☐N
			☐ Y ☐N
			☐ Y ☐N
			☐ Y ☐N
			☐ Y ☐N

Psychiatric History

IS THERE FAMILY HISTORY OF ANY OF THE FOLLOWING?

MOTHER:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

FATHER:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

SIBLINGS:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

EXTENDED FAMILY/GRANDPARENTS:
- ☐ ADD/ADHD
- ☐ Alcohol Addiction
- ☐ Substance Abuse
- ☐ Anxiety
- ☐ OCD
- ☐ Depression
- ☐ Bipolar
- ☐ Eating Disorder
- ☐ PTSD
- ☐ Schizophrenia
- ☐ Anger Management
- ☐ Personality Disorder
- ☐ Attempted Suicide
- ☐ Completed Suicide
- ☐ Other:

HAS CHILD USED COUNSELING SERVICES IN THE PAST? ☐ **Yes** ☐ **No**

Name of Counselor	Primary Reason	Location	Outcome/Was it helpful?
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

HAS CHILD HAD A PREVIOUS DIAGNOSIS OF

Anxiety ☐ Depression ☐ Panic ☐ ADHD ☐ OCD ☐ Panic ☐ Bipolar ☐ Anorexia ☐ Bulimia ☐PTSD ☐ Substance Abuse ☐ Alcoholism

HAS CHILD EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS? ☐ **Yes** ☐ **No**

When/Dates	Location	Purpose	Length of Stay

HAS CHILD EVER ATTEMPTED SUICIDE? ☐ **Yes** ☐ **No** **If Yes, then:**

Dates	Method	**Lethality** (required medical intervention?)

Educational History

Current School	Grade	Teacher

Past Schools	Grades	Teachers

Has your child been diagnosed with any of the following?

☐Cognitive Disorder ☐Autism ☐ Asperger's ☐ Learning Disorder ☐ Severe Head Injury ☐Seizures ☐ Speech/Language Problem

Educational Problems:	☐Math	☐Reading	☐Spelling
☐Dyslexia	☐Hyperlexia	☐Writing	☐Missing Work
☐Behavioral	☐Expressive Language	☐Attention/Focus	☐Frequent Absences
☐Forgets Work	☐Poor Grades	☐Dislikes School	☐Suspensions

Testing or placement for a learning disorder/special education: ☐Y ☐ N

Testing or placement in a gifted and talented program: ☐Y ☐ N

Has child skipped or repeated a grade? ☐Y ☐ N Which grade? _____

Does your child experience behavioral problems at school? Please describe:

Developmental History

PREGNANCY

☐Normal	☐Smoking	☐Severe Morning Sickness	☐Staining or blood loss	☐Threatened Miscarriage
☐Infections	☐Alcohol Use	☐Drug Use	☐Toxemia	☐Other

DELIVERY/POST DELIVERY

☐Full-Term	☐Premature/Wks:	☐Spontaneous/Hrs.	☐Induced/Hrs.
☐Vaginal	☐C-Section:	☐Breech	☐Complications:
☐Jaundice	☐Cyanosis (blue baby)	☐Infection	☐NICU/Days/Wks:

INFANCY (0-6MONTHS)

☐No Issues	☐Separation Anxiety	☐Attachment:
☐Feeding Issues:	☐Excessively Irritable	☐Sleep Problems:
☐Difficult to Comfort:	☐Did not like being held:	
☐Head Injuries:	☐Major Illnesses:	

DEVELOPMENTAL MILESTONES

	Normal	***Early***	***Late***	***Comments***
Eating Solid Foods	☐	☐	☐	
Sat Without Support	☐	☐	☐	
Crawled	☐	☐	☐	
Walked	☐	☐	☐	
Spoke First Words	☐	☐	☐	
Spoke Sentences	☐	☐	☐	
Fine Motor Skills	☐	☐	☐	
Gross Motor Skills	☐	☐	☐	
Toilet Trained	☐	☐	☐	
Puberty	☐	☐	☐	

Any skills that were gained and then lost? Describe*:*

Sensitivities/low tolerance for: ☐ Sounds ☐ Lights ☐ Foods ☐Textures ☐ Other:

Medical Information

Primary Care

Primary Care Physician:

Office Address:

Phone Number: Fax:

Medical History

Current/Past Medical Conditions

☐Heart Disease	☐Anemia	☐Headaches/Migraines	☐Stroke	☐Arthritis	☐Hepatitis
☐Shortness of breath	☐Asthma	☐Diabetes	☐Kidney Problems	☐Cancer	☐Menstrual Problems
☐High Cholesterol	☐Hormone Imbalance	☐Dementia	☐Liver Problems	☐Thyroid	☐Sleep Apnea
☐High Blood Pressure	☐Seizures/Epilepsy	☐Head Trauma	☐Ulcers	☐Fibromyalgia	☐Smoke

Other:

Do you have allergies: ☐ Y ☐ N List:

Are you currently taking medication? : ☐ Y ☐ N

Name of Medication	Dosage	Frequency	Purpose

Family History Of Illness/Disease

☐None	☐ Cancer	☐ Asthma	☐ Heart Disease
☐Diabetes	☐ High Blood Pressure	☐ Thyroid	☐Epilepsy
☐ Dementia/Alzheimer's	☐Hormone Imbalance	☐ Migraines	☐Other:

Current Psychiatric Care

Other Mental Health Providers:

☐ Psychiatrist ☐Developmental Therapy ☐Case Management ☐Service Coordination ☐CBRS ☐Other:

Name of Provider/s	Location	Phone

CURRENT PSYCHIATRIC MEDICATIONS

Name of Medication	Dosage	Frequency	Purpose

Personal Resources

Describe your child's personal strengths and interests:

What you like to see improve as a result of counseling?

Would including spirituality in your child's counseling be beneficial? ☐ Yes ☐ No ☐ Not sure

Describe religious background and/or preference?