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ADOLESCENT HEALTH HISTORY AND PATIENT INFORMATION

Please complete this form and bring it with you to your first session.

Biographical Information

Adolescent's Name: _____

Gender: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____

Age: _____

Grade: _____ School: _____

Ethnicity/Race: _____

Your name: _____

Relationship to the adolescent: _____

Are you the adolescent's legal guardian?: _____

Please list all the people currently living in the same household with the adolescent (including yourself and the adolescent):

Name	Age	Relationship to Adolescent

Referred by: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact's Relationship to the Patient: _____

Your Home Phone: _____ Is it OK to leave a message? ☐ No ☐ Yes

Your Cell Phone: _____ Is it OK to leave a message? ☐ No ☐ Yes

Your Work Phone: _____ Is it OK to leave a message? ☐ No ☐ Yes

Your Email: _____ Is it OK to email you? ☐ No ☐ Yes

Health/Medical History

(Please answer the following questions with the adolescent as the subject of the question)

How would you describe the adolescent's physical health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Any significant medical issues (current/past)? ☐ No ☐ Yes

If yes, please describe: _____

_____

Date of last physical exam? _____ Allergies:_____

Any past hospitalizations, surgeries, or serious injuries? ☐ No ☐ Yes

If yes, please describe _____

Any past head injuries or injuries that resulted in a loss of consciousness? ☐ No ☐ Yes

If yes, please explain _____

Any family members with psychiatric or substance abuse problems (current/past)? ☐ No ☐ Yes

If yes, please describe _____

Has the adolescent ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, please describe _____

Has the adolescent ever tried to harm or kill his or her self? ☐ No ☐ Yes

If yes, please describe _____

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Has the adolescent ever experienced suicidal thoughts? ☐ No ☐ Yes

If yes, please describe _____

Has the adolescent taken any psychiatric medications in the past? ☐ No ☐ Yes

Previous Mental Health Treatment

Has the adolescent ever seen anyone for psychotherapy? ☐ No ☐ Yes

If Yes, (number of times/how long)? _____

Is the adolescent currently under the care of a psychiatrist/psychologist/therapist? ☐ No ☐ Yes

If Yes (Name/Location) _____

Does the adolescent have a primary care physician (or clinic)? ☐ No ☐ Yes

If Yes (Name/Location) _____

What medication(s) is the adolescent currently taking, including psychiatric and other medications?

_____

Please describe the concerns that have brought you to seek therapy for the adolescent at this time.

_____

_____

_____

_____