

SOCIAL HISTORY/ADOLESCENT

To be completed by minor attending counseling

Please complete as much of this form as you feel comfortable. Your counselor will use it to help guide you in achieving your counseling goals.

NAME	AGE	GRADE	DOB	TODAY'S DATE

Please describe the circumstances you have been experiencing:

What do you hope will change by participating in counseling?

If you have experienced any of these symptoms please mark how often and when they began:

SYMPTOM	3 months	6 months	1 Year +	Year symptom began
Worried				
Sad				
No energy				
My mind won't turn off - racing thoughts				
Can't concentration				
Can't decide				
Can't fall asleep				
Change in appetite				
Angry outbursts				
Crying often # times per week _____				
Not motivated				
Weight change + or - _____				
Feeling others are against me				
Guilty				
Lonely				
Moody				
Hopeless feelings				
Low self confidence				
Trouble remembering				
Thoughts or plans to harm myself				
Thoughts or plans to harm others				

SCHOOL – list your class schedule below	Honors or Regular	On a scale of 1-5 with 1 being <i>little</i> and 5 being <i>a lot</i> , how much stress does this class cause?	Grade Average
1.		1 2 3 4 5	
2.		1 2 3 4 5	
3.		1 2 3 4 5	
4.		1 2 3 4 5	
5.		1 2 3 4 5	
6.		1 2 3 4 5	
7.		1 2 3 4 5	
8.		1 2 3 4 5	

What time do you usually arrive at school? _____ AM

What time do you usually leave school? _____ PM

FAMILY

Describe your current living situation:

Are your parents divorced? yes no

If YES, please answer remaining questions in this box or move to next set.

Your age at divorce _____ Did they remarry? yes no

Describe your relationship with your stepparent(s) if applicable:

Describe the events that led to your parent's divorce:

Which parent do you live with? mom dad both-explain _____

How often do you see your other parent: _____

Describe your parents relationship now:

Describe your best memory of your father:

What has been good about your relationship with your father:

If you could change anything about your relationship with your father, what would that be:

Describe your best memory of your mother:

What has been good about your relationship with your mother:

If you could change anything about your relationship with your mother, what would that be:

Describe your most hurtful childhood memory:

FAMILY Continued			
Sibling Name	Brother / Sister	Age	Describe your current relationship with this sibling

RELIGION

What church do you usually attend? _____

How involved are you and how often? _____

Finish this sentence: *God is...* _____

LEGAL

Have you ever been arrested? Yes No; *If yes, explain charges* _____

Date of arrest _____ Outcome/Status of arrest _____

Have you ever been convicted of a felon Yes No; *If yes, please explain* _____

Are you on probation? Yes No; *If yes, when does it end?* _____

Name and phone # of your Probation Officer _____

ALCOHOL/DRUG USE

Do you drink alcoholic beverages? Yes No; *If yes, how often?* _____

Are you concerned about your drinking habits? Yes No

Are your parents aware of your drinking habits? Yes No

Have others close to you showed concern about your drinking habits? Yes No; *If yes, please explain:*

Do you use illegal drugs? Yes No; *If yes; please list* _____

How often? _____

Are you concerned about your drug use/habits? Yes No

Are your parents aware of your drug use/habits? Yes No

Have others close to you showed concern for your drug use? Yes No; *If yes, please explain:*

SEXUALITY

Have you ever been sexually abused? yes no; *If yes, your age at the time(s) of the abuse(s)* _____;

age(s) of the abuser(s) _____; Are adults aware of this abuse? yes no

If yes, please list adult name? _____

Do you view internet/other pornography yes no; *If yes, how often* _____

Are your parents aware of your involvement in this activity? yes no

How concerned are you about your pornography habits, please explain: _____

ADOLESCENT INTAKE FORM

To be completed by PARENT/GUARDIAN of minor

How did you hear about our counseling office?

- Website/Internet Search
- Church Referral _____
- Other _____

Minor Child Contact Information

Name: _____ DOB: ____/____/____ Age: ____ Sex: M F

Address: _____
City State Zip

Home #: _____ Cell #: _____

Parent/Guardian Contact Information

Parent Name: _____ Sex: M F

Address: _____
City State Zip

Home #: _____ Cell #: _____

Occupation: _____

Current Marital Status of Minor's Parents

- Not Married Married Separated Widowed Divorced

Please explain if necessary, _____

Emergency Contact Person

The counselor has my permission to call the emergency contact person listed below in the event of an emergency situation where parent/guardian is unable to be reached.

Contact Person: _____ Relationship: _____

Telephone # _____

Parent/Guardian Signature _____ Date _____

Telephone Messages

The counselor has my permission to call at the telephone #'s I have provided to leave messages that include his name and number.

Parent/Guardian Signature _____ Date _____

Charles P. Coulter/Licensed Professional Counselor/Nationally Certified Counselor
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