Cognitive Performance & Health

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Cognitive Performance & Health

ADOLESCENT INFORMATION FORM

Name_____ Date of 1st Appointment_____ Therapist_____

Date of Birth_____ Age_____ Right or Left Handed _____ Gender: Male_____ Female_____

Address_____Email _____

Home Phone_____ Cell Phone_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____ Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer:_____

Current Medication being taken:

1)_____ Dosage/Freq_____ Start Date_____ Purpose_____

2)_____ Dosage/Freq_____ Start Date_____ Purpose_____

3)_____ Dosage/Freq_____ Start Date_____ Purpose_____

4)_____ Dosage/Freq_____ Start Date_____ Purpose_____

Prescribed by:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle One) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have allergies? (Circle One) YES NO

Do you have asthma? (Circle One) YES NO

Describe any important medical history, chronic ailments, or other health problems you experience:_____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties?

Please list:_____

_____

_____

Have you ever been hit in the head, blacked out, or had a concussion? (Circle One) YES NO

If yes, how old were you?_____ Were you hospitalized?_____

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Circle One) YES NO

If yes, please explain:_____

What was the last year of school you completed?_____ What school are you currently attending?_____

Who is in your current support network? (friends, relatives, other adults):_____

Please check all information which applies to your biological parents:

MOTHER		FATHER	
	_____living		_____living
	_____deceased		_____deceased
	_____married		_____married
	_____divorced		_____divorced
	_____remarried _____# of times		_____remarried _____# of times

With whom do you live? Mother_____ Father_____ Stepmother_____ Guardian_____ Grandparent_____

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?_____

_____

Were you adopted? (Circle One) YES NO

If yes, what was your age at this time?_____

Have you ever been in foster care? (Circle One) YES NO

If yes, what was your age at this time?_____

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

Name	Age	Relationship (biological, step, half, etc.)	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your relationship with your mother:

Currently:_____

_____

In the past:_____

_____

Describe your relationship with your father:

Currently:_____

_____

In the past:_____

_____

Describe your relationship with your stepmother:_____

_____

Describe your relationship with your stepfather:_____

_____

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse:_____

Sexual/physical/emotional abuse:_____

MENTAL STATUS

Please check any of the following that describe how you believe you feel:

_____sad _____anxious _____depressed _____frightened _____guilty _____angry _____aggressive _____resentful _____worthless

_____tearful _____irritable _____confused _____extreme ups/downs _____jealous _____hopeless _____helpless _____annoyed

Describe any other feelings you have had:_____

_____

Please check any of the following risk-taking behaviors you have engaged in:

_____street racing _____gang involvement _____skip school _____dropped out _____dangerous dieting _____cutting _____stealing

_____unprotected sex _____running away _____bullying others _____fire starting _____hurting animals _____restrict or restricted food intake

_____over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

_____beer _____wine _____hard liquor _____pot _____cocaine _____heroin _____Ecstasy _____speed _____over the counter drugs

_____prescription drugs _____ice _____Triple C's _____dones _____quad bars Other:_____

Have you had any change in sleeping habits? (Circle One) YES NO

Describe:_____

_____

Have you had any change in eating habits? (Circle One) YES NO

Describe:_____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates:_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problems? (Circle One) YES NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List any current problems you are having in daily psychological, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members):_____

_____

_____

What activities or hobbies do you participate in?_____

_____

Do you participate in regular exercise? (Circle One) YES NO

Describe:_____

How much time do you spend online or gaming?_____

Please circle any of the following concerns that your child or your family may be experiencing:

Nervousness	Toileting	Suicidal Thoughts	Nightmares
Shyness	Depression	Finances	Behavioral Problems
Separation/Divorce	Sexual Problems	Unhappiness	Temper
Drug Use	Alcohol	Work	Death of a Loved One
Anger	Self-Control	Tiredness	Appetite/Eating
Sleep	Stress	Ambition	Parenting
Relaxation	Headaches	Decision Making	Stomach Trouble
Legal Matters	Memory	Concentration	Marital Problems
Energy	Insomnia	Health Problems	Loneliness
Feeling Inferior	Education/School	Other:_____	

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses:

_____

_____

_____

_____

_____

Please list your Therapy goals:

_____

_____

_____

_____

_____

THANK YOU!