Client Information Sheet-- Teen

Name: _____ Age:_____Date of birth: _____

Home phone: _____ Cell phone: _____

Address: _____ City:_____ State: _____ Zip: _____

Email address: _____

School: _____ Grade: _____

Parents' or guardians' names: _____

Parent's phone number: _____

How did you hear of us? _____

Do you attend church? Yes/No If so, where? _____

Have you had any previous counseling? Yes/No
If so, when and where? _____
Was it helpful? Yes/No Why or why not? _____

Please briefly describe what has caused you to seek counseling today. If it is not your choice to come to counseling, whose idea was it and why?

_____

_____

Please describe what you hope to come from counseling. In other words, if counseling "works," how will you know?

_____

_____

_____

In your own words, please tell me about your relationship with God. In other words, Who is God to you and how is God a source of support for you?

_____

_____

What do you like to do for fun? _____

Please put a check beside any of the items below that describe problems you are now facing:

___Depression
___Anxiety/worry
___Change in grades
___Problems at school
___Physical problems/illness
___Spiritual crisis
___Thoughts of Suicide
___Past abuse—physical, sexual, or emotional
___Current abuse--- physical, sexual, or emotional
___Substance abuse
___Anger
___Problems with parents
___Problems with friends
___Eating Disorder
___Guilt
___Loss

Are you on any psychiatric medications? Yes/No If so, please list:

_____

Is there anything else you would like for me to know before we begin?

_____

_____