

Keys to Living Counseling Center

Adolescent Psychosocial History

Client Name _____

Date ____/____/____

Parent Name _____

Therapist _____

To be completed by therapist

Duty to Warn Explained

YES NO

Mandatory Reporting Explained

YES NO

Family History

Parents Names _____

Parents divorced? Y N Your age when divorced? ____ Parents living? Father Y N Mother Y N
Parents a current problem? Y N

If divorced and remarried what is the name of your step parent(s)? _____

Brothers and Sisters: (Circle those living in home)

Name

Sex

Age

Biological/Step siblings

| Name | Sex | Age | Biological/Step siblings |
|-------|-------|-------|--------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Any major health problems, alcohol/drug abuse, other addictive behaviors or mental health issues in your family:

Education:

Highest level of education/Grade completed _____ School attended _____

Problems at School? _____

Abuse: Any history of being sexually abused? Y N Any history of being physically abused? Y N

If yes, who was the abuser _____ When did the abuse take place _____

Was the abuse reported? Y N If yes, to whom? _____

Any abuse of any kind to other members of family? Y N If yes, to whom? _____

Nutrition/Exercise:

Currently on a special diet? Yes ___ No ___ Describe: _____

Balanced diet including fruits and vegetables? Yes ___ No ___

Intake of highly sweetened and/or caffeinated drinks? Amount/day _____

Exercise? _____

Recreation/hobbies? _____

Spirituality:

Desire to pursue counseling from a Christian perspective? Yes ___ No ___
Desire for prayer to open or close therapy session? Yes ___ No ___
Church affiliation: _____ Attendance: _____
Importance of own faith/spirituality? _____
Regularity of devotional/quiet time/meditation time? _____
Current spiritual/religious issues needing help with? _____

Medical History:

Current prescribed medications/dosage: _____
Prescribing physician: _____
Past hospitalizations, surgeries, medical issues _____
Current medical issues: _____
Allergies: _____ None known _____
Ongoing physical pain? Yes ___ No ___ Frequency? _____ Location? _____
When began? _____ Intensity (0 none -10 extreme) _____
Physical disabilities or limitations of movement, sight, or hearing? Yes ___ No ___
If yes, explain _____

Psych Treatment History:

Outpatient: Yes ___ No ___
Therapist or agency _____ Dates From/To _____ Problem/Area of Concern _____
Inpatient: History of hospitalizations/treatment: ie, emotional problems, drug/alcohol treatment: Y ___ N ___
Date(s): _____
Reason(s): _____

Risk:

Family history of suicide: Yes ___ No ___ Attempts? Yes ___ No ___
Personal history of suicidal thoughts: Yes ___ No ___ Attempts? Yes ___ No ___ When attempted: _____
How/Method: _____
Current suicidal thoughts: Yes ___ No ___ Plan _____
Thoughts of injuring or harming another person: Yes ___ No ___ If yes, explain _____

Substance use/abuse/addictions:

Tobacco use: Yes ___ No ___ Frequency: _____ Quantity: _____
Alcohol use: Frequency _____ Quantity _____ Problem? _____
Drug use: Frequency _____ Quantity _____ type _____ Problem? _____
Arrests for being under the influence of alcohol/drugs? Yes ___ No ___ # ___
Have you ever quit drinking or quit using drugs? Yes ___ No ___ # ___
Use of drugs (pot, speed, cocaine, etc.) or misuse of prescription drugs in past year? Yes ___ No ___
Describe: _____
Gambling: Yes ___ No ___ Describe _____
Pornography: Yes ___ No ___ Describe _____
Other addictions: _____

Legal:

History of legal convictions: _____
 Reason: _____

Incarcerations: jail: _____ prison: _____
 Currently involved with the court or legal system? Y N Past/present involvement with DHS? Y N Describe:

Finances:

Problems relating to finances. Describe:

Symptoms

Please check all of the following that apply – place a question mark by those you are unsure of:

Depression

- Suicide ideation/attempts
- Depressed/sad
- Discouraged
- Low energy
- Low motivation
- Appetite change
- Weight loss/gain
- Sleep problems
- Loss of enjoyment
- Loss of concentration
- Increased emotions
- Irritability
- Agitation
- Worthlessness
- Hopelessness
- Helplessness
- Difficulty coping

Anxiety

- Worry
- Headaches
- Stomach upset
- Dizziness
- Tired/fatigued
- Tense/nervous
- Chest tightness
- Poor sleep
- Irritable
- Trembling

Panic

- Palpitation
- Sweats
- Shakes/tremble
- Shortness of breath
- Chest pain
- Nausea
- Dizzy
- Fear of dying
- Agoraphobia

PTSD

- Trauma
- Nightmares
- Flashbacks
- Hypervigilant
- Avoidant
- Insomnia
- Startle response

OCD

- Obsession
- Obsessions
- Compulsions

ODD

- Argues
- Defiant
- Blames others
- Angry
- Vindictive
- Loses temper

Mania

- Grandiose
- Racing thoughts
- Minimal sleep
- Excessiveness
- Agitation

ADHD/ADD

- Short attention span
- Distractible
- Poor concentration
- Forgetful
- Organizational problems
- Fidgety/restless
- Impatient
- Underachievement
- Difficulty completing tasks
- Procrastination
- Misplaces things
- Easily frustrated
- Impulsive/reactive
- Hyperactive

Conduct disorder

- Cruelty
- Theft
- Aggression
- Fights
- Fire setting
- Destructive
- Run away
- Truant

Impairments to progress:

Complex circumstances _____ Chronic circumstances _____ Low motivation _____
 Unproductive past therapy _____ Chronic health probs _____ Interpersonal _____
 Occupational/Educational _____ Chronic emotional probs _____ Psychological _____ Compliance _____

Client strengths:

Spiritual faith _____ Motivation _____ Social support _____ Hopefulness _____ Honesty _____ Confidence _____
 Willingness to take responsibility _____ Accurate self assessment _____
 Others _____