

Adolescent Client Information Sheet

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Please provide the following information and answer the questions below as complete as possible. Please note information you provide here is protected as confidential information.

CLIENT INFORMATION

Full name: _____

Date of Birth: _____ Age: _____ Male _____ Female _____

Cell Phone: (____) _____ Messages okay? _____ Text okay? _____

School: _____

Please share electronic communication (Facebook, Twitter, Snapchat, Instagram, etc.) that you use:

Do your parents have access to your electronic communication? (Y/N) _____ Do they have any issues with your use of phone, text electronic communication? (Y/N) _____

PERSONAL STRENGTHS

What activities do you enjoy and feel you are successful when you try?

Who are some of the influential and supportive people, activities (e.g. walking) or beliefs (e.g. religion) in your life? (Please describe)

CURRENT REASON FOR SEEKING COUNSELING

Briefly describe the problem for which you are seeking to have counseling for?

What would you like to see happen as a result of counseling?

COUNSELING/MEDICAL HISTORY

Have you previously seen a counselor? Yes ____ No ____

If yes, what did you find **most helpful** in therapy?

If yes, what did you find **least helpful** in therapy?

CHEMICAL USE AND HISTORY

Do you currently use alcohol? Yes ____ No ____

If yes, how often do you drink? Daily ____ Weekly ____

Occasionally ____ Rarely ____

If yes, how much do you drink? _____ (#) per time

Do you currently use Tobacco? Yes ____ No ____

If yes, how much do you smoke / chew? _____

Do you currently use any other drugs? Yes ____ No ____

If yes, what drugs do you use?

If yes, how often do you use? Daily ____ Weekly ____ Occasionally ____

Rarely ____

Have you received any previous treatment for chemical use? Y/N _____

If so, where did you go?

Inpatient _____ Outpatient _____

Adolescents (please answer the following with Y/N)

1. Have you ever used more than 1 chemical at the same time to get high? _____
2. Do you avoid family activities so you can use? _____
3. Do you have a group of friends who also use? _____
4. Do you use to improve your emotions such as when you feel sad or depressed? _____

LEGAL ISSUES

Please list any legal issues that are affecting you or your family at present or have had a significant effect upon you in the past

FAMILY HISTORY

1. Are your parents married or divorced? _____
2. Do you think their relationship is good? (Y/N/Unsure) _____
3. If your parents are divorced, whom do you primarily live with? _____
4. How often do you see each parent? Mom _____% Dad _____%
5. Did you experience any abuse as a child in your home (physical, verbal emotional, or sexual) or outside of your home? Please describe as much as you feel comfortable.

FAMILY CONCERNS (Please check any family concerns that your family is currently experiencing)

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends

Loss of fun	Alcohol use
Lack of honesty	Drug use
Physical fights	Infidelity (couple)
Education problems	Divorce / separation
Financial problems	Issues regarding remarriage
Death of a family member	Birth of a sibling
Abuse/neglect	Birth of a child
Inadequate housing/feeling unsafe	Inadequate health insurance
Job change or job dissatisfaction	Other

Other concerns not listed above

PEER RELATIONS

1. How do you consider yourself socially: Outgoing _____ Shy _____ Depends on the situation _____
2. Are you happy with the amount of friends you have? (Y/N) _____
3. Have you ever been bullied? (Y/N) _____
4. Have you ever bullied other people? (Y/N) _____
5. Are your parents happy with your friends? (Y/N) _____
6. Are you involved in any organized social activities (e.g. sports, scouts, music)? _____

SCHOOL HISTORY

1. Do you like school? (Y/N) _____
2. Do you attend regularly? (Y/N) _____
3. What are your current grades? _____
4. Do you feel you are doing the best you can at school? (Y/N) _____

ADOLESCENT INTAKE FORM (PARENT SECTION)

Adolescents's Name: _____

Date of Birth: _____ Age: _____ Male _____ Female _____

Race/Ethnic Origin: _____

Religious Preference: _____

CURRENT HOUSEHOLD AND FAMILY INFORMATION

Name	Relationship (Parent, sibling, etc.)	Age	Sex	Type (bio, step, etc)	Living with you? Y/N

(if additional space is needed, please list on the back)

Current Reason for Seeking Counseling For Your Adolescent.

Briefly describe the problem for which your adolescent is seeking to have counseling for?

What would you like to see happen as a result of counseling?

What is most concerning right now?

CHILD'S DEVELOPMENT

1. Were there any complications with the pregnancy or delivery of your child?
Yes _____ No _____ If yes, please describe:

2. Did your child have health problems at birth? Yes _____ No _____ If yes, describe: _____
3. Did your child experience any developmental delays (e.g. toilet training, walking, talking)? Yes _____ No _____ If yes, describe: _____
4. Did your child have any unusual behavior or problems prior to age 3? Yes _____ No _____ Not sure _____ If yes, describe: _____
5. Has your child experienced emotional, physical, or sexual abuse? Yes _____ No _____ Not sure _____ If yes, describe: _____

COUNSELING HISTORY

Has your son or daughter seen a counselor? Yes _____ No _____

If yes, where: _____

Approximate dates of counseling: _____

For what reason did your son or daughter go to counseling?

Does your son or daughter have a previous mental health diagnosis?

What did you find most helpful in therapy?

What did you find least helpful in therapy?

Has your son or daughter used psychiatric services? Yes _____ No _____

If yes, who did they see? _____

If yes, was it helpful? N/A _____ Yes _____ No _____

Has your son or daughter taken medication for a mental health concern? Yes _____ No _____

Name of medication	Dates taken

Does your son or daughter have other medical concerns or previous hospitalizations? Y/N _____ If yes, please describe:

CHEMICAL USE

Do you have any concerns with your son or daughter using alcohol or drugs? (Y/N) _____ If yes, please explain your concern:

INTERNET/ELECTRONIC COMMUNICATIONS USAGE

Do you have any concerns with your son or daughter using the internet or electronic communications such as Facebook, Snapchat, Twitter, texting, etc.? (Y/N) _____ If yes, please explain your concern:

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, son or daughter, or have had a significant effect upon you or your son or daughter in the past.

FAMILY HISTORY

Are you aware of any birth trauma your son or daughter experienced from age 0-3? _____

Did you experience any abuse as a child in your home (physical, verbal, emotional, or sexual) or outside your home? Please describe as much as you feel comfortable.

Have you experienced any abuse in your adult life (physical, verbal, emotional, or sexual)?

PARENT'S MARITAL STATUS *(this question refers to the biological parents relationship)*

Single _____ Married (Legally) _____ Divorced _____ Cohabiting _____

Divorce in process _____ Separated _____ Widowed _____ Other _____

Length of marriage/relationship: _____ If divorced, how old was your child at time of divorce? _____

If divorced, how much time does your child spend with each parent?

Mom _____% Dad _____%

(Please answer the following as best you can)

Biological Father's Name: _____

Ethnic Origin: _____ Birth Date: _____

Total years of educations completed: _____ Occupation: _____

Place of Employment: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current status: Single _____ Married _____ Divorced _____ Separated _____

Widowed _____ Other _____

Assessment of current relationship if applicable: Poor _____ Fair _____ Good _____

Biological Mother's Name: _____

Ethnic Origin: _____ Birth Date: _____

Total years of education completed: _____ Occupation: _____

Military experience? Y/N _____ Combat experience? Y/N _____

Current status: Single _____ Married _____ Divorced _____ Separated _____

Widowed _____ Other _____

Assessment of current relationship if applicable: Poor _____ Fair _____ Good _____

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your son or daughter is successful when they try?

What personal qualities would you say your son or daughter has?

Who are some of the influential and supportive people, activities(e.g. walking) or beliefs (e.g. religion) in your son or daughter's life? (Please describe)

Is there anything else you would like to share:

Special Confidentiality Notice for Parents

Your child has the right to private, confidential communication with the doctor, therapist, and treatment team providing his or her care. This means that some of the issues that they discuss will stay between them, and that we will not disclose that information to anyone, including you, unless we have been given permission by your child to do so. We need your child to be open and honest with us in order to understand and treat the full range of issues your child is dealing with, and they may be too scared, angry or ashamed right now to share those issues with you. We also recognize it is very important for you to know what your child is going through in order to do your job as a parent, which is why we will always encourage your child to be honest with you. We will encourage, prepare, and support your child so that they feel safe enough to share those issues with you.

According to California law, and the federal patient privacy law known as HIPAA, your child will need to give his/her consent for us to disclose:

- All Mental Health records for children age 16 or older.
- All information concerning pregnancy, sexual activity, STD's, and drugs/ alcohol use or abuse regardless of child's age.
- Any information that your child's providers believes, if released could cause harm to your child or to someone else, or that would significantly harm the treatment relationship with your child.
- You should know this confidentiality has limits. If there is any threat to your child's life, we have the duty to inform you and help to create a plan for safety.
- There are situations that we are mandated to report and cannot keep confidential. Those situations include: threats against another person, physical or sexual abuse, neglect, and pregnant women who report using drugs.
- We recognize how challenging it can be for a parent to raise a child, especially when the child has a mental illness. We know how badly you might want to know everything your child has kept a secret from you, too. We want to be your partner in supporting your child's physical and mental wellbeing, and even when we can't discuss certain details about your child with you, we will always be there for you: guiding you and giving your child the best advice

possible to protect him/her and encourage healthy decisions, including being open and honest with you.