

# Confidential Information Sheet - Teen

(to be filled out by teen)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (C): \_\_\_\_\_ OK to leave message? Y / N

Phone (H): \_\_\_\_\_ OK to leave message? Y / N

Email: \_\_\_\_\_ OK to use? Y / N (note: email is not secure)

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Job: \_\_\_\_\_

Date of Birth \_\_\_\_\_ About how long since last Medical Check-Up: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Religion / Spirituality (if any): \_\_\_\_\_

Whose idea was it for you to come here?       Mine       Parents       Other

If someone else, are you OK with this idea?    Yes       No       Not Sure

Main reason(s) for seeking help: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How long ago did this start? \_\_\_\_\_  
 \_\_\_\_\_

What have you tried? \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY**

With whom do you live? \_\_\_\_\_

How often do you see your father? daily / weekly / monthly / once a year / never

How often do you see your mother? daily / weekly / monthly / once a year / never

Describe your family:	Mother	Father	Step-mother	Step-father	Brother	Sister	Other
Likes me							
Kind							
Pleasant							
Understanding							
Easygoing							
Rarely home							
Strict							
Mean							
Critical							
Negative							
Angry							
Uses drugs							
Uses alcohol							
Verbally abusive							
Physically abusive							

Kind of punishment - indicate who:

	Mother	Father	Step-mother	Step-father	Other
Sends you to your room					
Takes away privileges					
Restricts or grounds you					
Spanks / hits					
Other					

### MEDICAL

Do you have or have you had any major medical problems or been hospitalized?  Yes  No

If so, please list: \_\_\_\_\_

Are you on any medications (including birth control pills)?  Yes  No

If so, please list: \_\_\_\_\_

Are you, or have you been, sexually active?  Yes  No

Do you practice safe sex?  Yes  No

What is your sexual orientation? \_\_\_\_\_

For females: Have you stated your period?  No  Yes At what age? \_\_\_\_

Are you pregnant?  Yes  No

Have you ever been pregnant?  Yes  No

Have you ever drank alcohol?  Yes  No How often? \_\_\_\_\_

Do you smoke or use tobacco?  Yes  No

Do you use drugs?  No  Yes If so, what kind? \_\_\_\_\_

Do you think your drug or alcohol use is a problem?  Yes  No

### PROBLEMS / SYMPTOMS

Please check off any items that apply to you:

Now	Past		Now	Past		Now	Past	
___	___	Restless	___	___	Sexual Problems	___	___	Memory problems
___	___	Act without thinking	___	___	Problems with the law	___	___	Hard to make decisions
___	___	Enjoy 'bugging' people	___	___	Fire-setting	___	___	Irritable / angry
___	___	Low motivation	___	___	Hurt people	___	___	Withdrawn from others
___	___	Easily frustrated	___	___	Very anxious	___	___	Trouble concentrating
___	___	Daydream or fantasize a lot	___	___	Worry more than others	___	___	Sadness, crying or depression
___	___	Temper outbursts	___	___	Fearful	___	___	Nothing fun any more
___	___	Back talk / Argue a lot	___	___	Nervous / can't relax	___	___	Low self-esteem
___	___	Hard to admit mistakes	___	___	Damaged property	___	___	Sleep problems
___	___	Difficulty paying attention	___	___	Want to run away from home	___	___	Have run away from home
___	___	Repeat an unnecessary act over and over	___	___	Eat little or fast to lose weight	___	___	Nightmares, night terrors
___	___	Hurt animals	___	___	Sneak out at night	___	___	Binge on food
___	___	Stolen things	___	___	Tired, fatigued	___	___	Attempted suicide
___	___	Hear voices or see things that aren't there	___	___	Vomit food on purpose	___	___	Too worried about germs, safety, health
___	___	Other: _____						

**Check the boxes that describe your relationships with others:**

- Prefer to be alone
- Alone a lot, but feel lonely
- Problem getting along with others
- Shy
- Hard to get along with siblings
- Conflict with my parents or step-parents
- Family member drinks too much
- Family member uses drugs
- Family member, relative, or friend tried to kill him/herself
- I have a best friend
- I have a lot of friends
- I go out with friends. Where to? \_\_\_\_\_
- I have a steady boyfriend or girlfriend. Their age? \_\_\_\_\_
- Being physically or sexually abused
- Being neglected
- Getting picked on a lot by peers
- Getting picked on a lot by family member

**I have had these problems at school:**

- Difficulties with classmates
- Not having friends at school
- Not getting along with teachers
- Cutting school or class a lot
- Poor grades
- Learning problems
- Detention or Saturday school
- Been suspended (How many times? \_\_\_\_\_)
- Been expelled (How many times? \_\_\_\_\_)
- Getting in fights at school

**Have you had any of the following experiences or problems, now or in the past?**

	None or a little of the time	Some of the time	Good part of the time	Most of all of the time
It feels too painful to keep on living				
I feel my family would be better off if I were dead				
I think about suicide				
I have thought of how to kill myself				
In order to punish others, I think of suicide				

**LEGAL**

Have you ever been involved with the police or court? Check one:

- No     Yes, in the past month     Yes, in the past 6 months     Yes, over 6 months ago

Do you see a social worker or probation officer regularly?     No     Yes

If so, what is their name and phone number? \_\_\_\_\_

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**OTHER**

What happened *now* that got you to seek help? \_\_\_\_\_

Who else is helping you with this problem? \_\_\_\_\_

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Have you ever seen a counselor or therapist in the past?     Yes     No

If so, when? \_\_\_\_\_ Whom did you see? \_\_\_\_\_

For what? \_\_\_\_\_ Was it helpful?     Yes     No

If so, how? \_\_\_\_\_

Is there anything else I should know that might be important?

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Thank you.