# 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 | | | | | | | |

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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: _____ | | | | | | |

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**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? _____

_____

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?

_____

_____

Thank you.

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