Solace Crisis Treatment Center

Personal History Checklist For Adolescents (Adolescent to Complete)

It is the goal of our center to have the most complete picture possible of you to better understand how to best help you. You and the therapist will both have the opportunity to talk about these questions as well as other concerns during your intake assessment.

Your Full Name: _____Today's Date: _____

How did you hear about our services? _____

Why are you are seeking counseling services at this time?

_____

_____

How are you coping with your situation? _____

_____

Whom do you turn to for support or who helps you cope?

_____

How do you express your emotions?

_____

Have you now or ever in the past had any of the following?

(Please circle those that describe you)

Arguing	Clumsy	Disruptive	Fighting at School	Lacks Confidence	Runs Away
Anxious	Depressed or Sad Unhappy	Demands Attention	Easily Frustrated	Lies/Steals/Cheats	School Refusal
Aggressive	Discouraged Easily	Frequent Confusion	Frequent Cursing Vulgar Language	Legal Violations	Refuses to Do Chores
Bed wetting/Soiling Clothes	Damages Property	Fearful or Worried	Impulsive or Poor Judgment	Nightmares	Truancy
Bizarre or Odd Behavior	Difficulty Following Rules	Fire setting	Intimidates or Threatens Others	Poor Concentration	Tires Easily

Have you been losing your temper more often lately? Yes / No

What do you do when you lose your temper?

_____

Have you noticed that you are having more conflicts with others recently? Yes / No

If yes, please describe:

_____

Do loud noises startle of frighten you more than before? Yes / No

Do you have thoughts of harming yourself? Yes / No

Do you have thoughts of killing yourself? Yes / No

If yes, what are those thoughts?

_____

Have you ever attempted suicide in the past? Yes / No

If yes, please describe how and why?

_____

_____

Do you have thoughts of harming anyone else? Yes / No

If yes, please explain:

_____

In the space below, please describe any other things that you have noticed about yourself or that you are worrying about:

_____

_____

Have you ever seen a counselor? Yes / No

If yes, when was the last time you saw him/her? _____

What is your counselor's name? _____

Please describe the reason you went to see the counselor:

_____

Have you ever been hospitalized for mental or emotional reasons? Yes / No

If yes, when and where? _____

Have you ever harmed or been abusive towards animals? Yes / No

If yes, please explain:

_____

Have you ever harmed yourself on purpose (cutting, burning etc)? Yes / No

If yes, please explain:

_____

Have you experienced a significant loss or upsetting experience in the past two years (e.g., moving, change schools, a break-up, death of a relative, gang violence, physical assault)? Yes / No

If yes, please explain:

_____

_____

Family Background

Which best describes your parents' relationship?

___ married ___ living together ___ separated ___ divorced ___ single parent ___ other:

Number of years if married: _____ If divorced, date (year) of divorce: _____

If your parents are separated or divorced, please explain the custody and visitation arrangement:

_____

If remarried, when: Mother _____ Father_____

Name of Step-parent: _____ Name of Step-parent:_____

Have you ever lived outside your home? Yes / No

If yes, with whom, how long, and reason:

_____

Do you have trouble getting along with family members? If so whom, describe what the trouble is:

_____

_____

Please indicate if you have experienced any of the following:

Physical abuse: Yes / No Emotional abuse: Yes / No Sexual abuse: Yes / No

If Yes to any of the above please explain when and by whom:

_____

_____

Military Background

Have any of the following relatives served in the military?

- Father
- Mother
- Sister
- Brother
- Uncle
- Son
- Daughter
- Grandmother
- Grandfather
- Aunt
- Do not know
- None
- Other
- Spouse

Eating and Sleeping Habits

What time do you go to bed at night? _____

What time do you wake up in the morning? _____

Are you having difficulty with any of the following: (Circle **all** that apply)

Falling Asleep Staying Asleep

Waking up too early Sleeping more than usual

Are you having disturbing dreams or nightmares? Yes / No

Do you have enough to eat on a daily basis? Yes / No

Your appetite is: poor / fair / good

Do you feel like you have enough energy? Yes / No

Please list any food allergies:

_____

Are you on a special diet? Yes / No

If yes, explain:

_____

Do you ever stop yourself from eating or throw up after you eat? Yes / No

If yes, please explain:

_____

Educational History

Please list all schools attended beginning with current school

Name of School	City/State	Grades Attended

Are you having trouble in school? Yes / No

If yes, please describe:_____

Have you ever skipped a grade? Yes / No

If yes, which grade and why?_____

Have you ever been held back or made to repeat a grade? Yes / No

If yes, which grade and why? _____

Have had frequent absences in any grade? Yes / No

If Yes, please explain: _____

Have you ever been suspended or expelled from a school? Yes / No

If Yes, please explain: _____

Have you ever received support services such as Bilingual Ed, IEP's, special Ed, etc.? Yes / No

If Yes, please explain: _____

Medical History

Primary Care Physician/ Clinician: _____

Do you want us to contact your Primary Care Physician? Yes / No

If yes, for what purpose? _____

If No, why not? _____

Date of your last physical exam: _____

General Health: Very Good ____ Good ____ Average ____ Poor ____

Dental Health: Very Good ____ Good ____ Average ____ Poor ____

Are you experiencing any physical pain currently? Yes / No

If yes, please circle the severity level, with a "0" being no pain and "10" being unbearable:

No Pain<0__1___2___3___4___5___6___7___8___9___10___>Unbearable

Have you ever had a head injury or been knocked unconscious? Yes / No

If yes, please say how and when:_____

Have you ever had a seizure? Yes / No

If yes, when & why? _____

Do you have any speech or hearing problems? Yes / No

If yes, please describe: _____

Please List All Current Medications

Medication	Prescribing Doctor	Dosage	When started

Please list any allergies and their reactions that you have:

_____

Please check if you currently have or have had in the past.

- High prolonged fevers
- Chronic illness
- Severe allergies
- Disabilities/congenital condition
- Serious accidents/injuries(head injury, etc)
- Excessive # of injuries (accident prone)
- Stomach pains
- Physical limitations
- Major Surgeries
- Heart Problems
- Sleeping problems
- Tics/twitches
- Ear tubes
- Rashes
- Asthma
- Headaches
- Seizures
- Frequent infections
- Other _____

Please list any past illnesses, surgeries or hospitalizations:

_____

Quality of Life Concerns

Financial History:

__No current problems __Poverty or below poverty income __Impulsive spending __ Conflicts over finances

Living Situation:

__Housing adequate __Dependent on others for housing __Housing overcrowded

__Housing dangerous/deteriorating __Housing unsatisfactory __Homeless

Legal History:

__No current legal problems __Arrest(s) substance related __Now on probation/parole

__Arrest(s) not substance related __Court ordered this treatment __Have had jail/prison time

Are you currently engaged in community or recreational activities? Yes / No

If yes, please list: _____

Are you currently engaged in satisfying hobbies? Yes / No

If yes, please list: _____

Are you currently engaged in spiritual activities? Yes / No

If yes, please list: _____

Basic Life Skills:

(Please indicate if you have difficulties with any areas listed below)

Transportation: Yes / No

Reading or Writing: Yes / No

Obtaining dental care: Yes / No

Health/hygiene: Yes / No

Keeping appointments: Yes / No

Managing Money: Yes / No

Obtaining adequate nutrition: Yes / No

Using leisure time: Yes / No

Is CYFD involved now or have they been involved in the past? Yes / No

If Yes, Social Worker's Name: _____

Substance Abuse History

Please indicate any substances you have used in the past or are currently using:

Substance	Past use?	Currently Using?	How often?	How much?	Date first used:
Caffeine (tea, soda…)					
Tobacco					
Alcohol					
Marijuana					
Cocaine					
Heroin					
Barbiturates					
Amphetamines					
Ecstasy					
Inhalants					
Hallucinogens					
Other:					

Please answer the following questions about substance use:

Have you ever been treated for drug abuse or alcohol problems, or gone to a 12-step program? Y / N

If Yes, Date: _____

Have you ever been charged with DWI/DUI, or gotten into trouble with the law for drug or alcohol use? Y / N

If Yes, when? _____

Have you ever felt that you should, or actually tried, to cut down on your drug or alcohol use? Y / N

Do you get angry or annoyed when others comment on or criticize your drinking or drug use? Y / N

Have you ever felt guilty or bad about your use of alcohol or other drugs? Y / N

Do you ever need an "eye-opener" or early morning drink to steady your nerves or get rid of a hangover? Y / N

If you use drugs and/or alcohol, has your usage increased? Y / N

Sexual History

Are you currently sexually active? Yes / No

If yes, at what age did you become sexually active? _____

Was your first sexual experience by choice or by force? Please circle: Choice / Force

If by force, please explain:

_____

_____

When was the last time you were sexually active? _____

Are your current sexual experiences satisfactory? Yes / No

In the last month has your sexual activity: Increased ___ Decreased ____ Stayed the Same _____

Have your thoughts or feelings about sexual activity changed recently? Yes / No

If yes, please explain: _____

Have you ever been pregnant or gotten someone pregnant? Yes / No

If yes, when? _____

And was the pregnancy a result of a sexual assault? Yes / No

Have any of the following relatives been sexually abused or assaulted?

- Father
- Mother
- Grandmother
- Do not know
- Sister
- Brother
- Grandfather
- None
- Uncle
- Aunt
- Cousin
- Other: _____

If the above questions have not provided an opportunity for you to explain something that you think is important for your counselor to know, please use this space to do so:

_____

_____

_____