Center for Counseling & Family Relationships
4500 Mercantile Plaza, Ste 307
Ft. Worth, Texas 76137
Metro: 817-232-9400 Fax: 817-232-9403
www.ccfam.com

Confidential Client History

For Teens (Ages 13-17)

The purpose of this questionnaire is to help your counselor get a good picture of you. By completing these questions as best as you can, you will be helping your counselor to understand you and your particular situation and needs. Please be honest in order for your counselor to be able to know how to best help you.

Name________________________________Nickname______________________________________

What is your main problem today?

____

____

Did you want to come to counseling today? __________ Yes __________ No

What are some ways you have tried to solve this problem before?

____

____

Health/Medical History

Please check those you have been having trouble with:

_______Headaches
_______Trouble concentrating
_______Feeling afraid
_______Feeling all alone
_______Waking up a lot at night
_______Nightmares
_______Overeating
_______Sad most of the time
_______Not being able to control your anger
_______Upset stomach or feeling that you need to throw up
_______Memory
_______Unwanted thoughts
_______Hearing voices
_______Trouble falling asleep
_______Waking up real early
_______Less hungry lately
_______Afraid to eat
_______Angry most of the time
_______Not interested in things you used used to do anymore
_______Having to repeat the same things over and over

Have you ever thought of hurting yourself? _______Yes _______No
If yes, have you ever tried to hurt yourself? _______Yes _______No

Do you ever feel that you could hurt someone else? _______Yes _______No
Have you ever hurt someone else? _______Yes _______No

Family Information

What is the thing you like best about your parents or family?
____
____

Who in your family do you feel the closest to?
Why?____
____

Please check any that have happened in your family:

________Parents don't live together
________Somebody died
________Someone takes drugs
________Someone hits
________We have lots of money problems
________Someone drinks too much
________Someone is very sick
________Someone has problems with the law
________Other____

Alcohol/Drug History

Have you ever used alcohol or drugs? ________Yes ________No
If yes, what did you use?_____________________________________
When and why did you use?____________________________________
____

Do you think anyone in your family has a problem with alcohol or drugs? ________Yes________No

School History

Is there anything that bothers you about school? ________Yes ________No
If yes, what?____
____

What do you like best about school?___________________________
____

What are your friends like?__________________________________
____

Why did you choose them to be your friends?___________________
____

Where do you usually go and what do you usually do after school?_______________
____

Self-Description

What do you like least about yourself?____

____

What do you like most about yourself?____

____

If you could change anything in your life, what would it be?__________________________

____

Please tell me about any hobbies or things you are interested in (i.e. music, sports, church, other):

____

____

If you would like to tell me anything else, please use the bottom or back of this page.

Teen's Signature_________________________________**Date**________________

Client Name Printed:______________________________

Counselor: ________________