CENTER FOR COUNSELING
& FAMILY RELATIONSHIPS

Center for Counseling & Family Relationships
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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
_____Other_____
_____We have lots of money problems
_____Someone drinks too much
_____Someone is very sick
_____Someone has problems with the law

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: _____