Center for Counseling & Family Relationships
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Confidential History for Middle School/High School
(Ages 12-17)

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: ____________________