

## Adolescent Information Form

Name \_\_\_\_\_ Date \_\_\_\_\_ Your Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
Your cell phone number \_\_\_\_\_

How tall are you? \_\_\_\_\_ How much do you weigh? \_\_\_\_\_  
Who is your doctor? \_\_\_\_\_  
Date of your last exam \_\_\_\_\_  
What physical or medical problems do you have or have you had in the past?

\_\_\_\_\_  
\_\_\_\_\_

Are you on any medications? If so please list them \_\_\_\_\_

Do you have any allergies? If so what are they? \_\_\_\_\_

\_\_\_\_\_

Parents' Names \_\_\_\_\_

Parents' Addresses:

Mother \_\_\_\_\_ Phone \_\_\_\_\_

Father \_\_\_\_\_ Phone \_\_\_\_\_

Are your parents married or divorce? \_\_\_\_\_

Which parent do you live with? \_\_\_\_\_ Number of years \_\_\_\_\_

Bothers or sisters \_\_\_\_\_

Stepbrothers or stepsisters \_\_\_\_\_

Who lives in you home?

\_\_\_\_\_

Problems at home \_\_\_\_\_

\_\_\_\_\_

Are you adopted? \_\_\_\_ If so, at what age? \_\_\_\_\_

\_\_\_\_\_

What school do you go to? \_\_\_\_\_

Grade level/year \_\_\_\_\_

How are your grades?

\_\_\_\_\_

What are your extracurricular activities \_\_\_\_\_

\_\_\_\_\_

Problems in school \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you work? \_\_\_\_\_ If so where? \_\_\_\_\_

How many hours a week? \_\_\_\_\_

Have you had previous counseling? If so with whom? \_\_\_\_\_  
When? \_\_\_\_\_ For what? \_\_\_\_\_

What worries or upsets you?

\_\_\_\_\_  
\_\_\_\_\_

Why do you think you are here? \_\_\_\_\_

\_\_\_\_\_

Please let me know anything else that is important to you?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your Signature \_\_\_\_\_ Date \_\_\_\_\_

*PLEASE FILL OUT THE DAILY LIVING PROFILE, Thanks*