Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

ADOLESCENT INFORMATION

Dx code: _____

Welcome to Lunday Counseling Center. In order for us to gain a better understand of your adolescent and his/her needs please complete the following information. Please answer questions to the best of your knowledge. Some questions may not apply to your adolescent. Write N/A if they do not apply.

About you (parent)

Your Name: _____ Relationship to adolescent:_____

Street Address: _____ City, State, Zip:_____

Can we write you here? Yes / No

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Can we leave a message at Home: Yes / No Work: Yes / No Cell: Yes / No

Email: _____

Can we email you here? Yes / No

Your Marital Status: □ Single

□ Married: How long? _____; When? _____ (mo/yr);

# of marriages _____

□ Separated: How long? _____; when? _____ (mo/yr)

□ Divorced: How long? _____; When? _____ (mo/yr)

□ Widowed: How long? _____; When? _____ (mo/yr)

Current Spouse's Name (if applicable) _____ Age _____

Spouse's Phone (in case of emergency): _____

Previous Spouse's Name(s) - *if applicable*: _____

Names of children

First name	Last name	Age	Lives in your home
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time
_____	_____	_____	□ Yes □ No □ Part time

Who can we contact in case of an **emergency**? (Must be an adult other than yourself)

Name: _____ Phone: _____

Address: _____ City, State, Zip:_____

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About your adolescent (ages 13-18)

Adolescent's Name: _____ Date: _____

Date of Birth: _____ Sex: € M € F Current Age: _____

Adolescent lives with: _____

Is this location the same address as above? € Yes € No

If not, please provide their address:_____

_____

MEDICAL INFORMATION

How would you rate your adolescent's current physical health? □ Excellent □ Good □ Fair □ Poor

Is he/she currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)?

□ Yes □ No If yes, please explain: _____

Previous hospitalizations for medical reasons Date:_____ Reason: _____

Medical conditions or disabilities: _____

Learning or other disabilities not listed: _____

To your knowledge, has your adolescent ever had an abortion? □ Yes □ No If yes, how many? _____ when?_____

To your knowledge, is your adolescent currently sexually active? □ Yes □ No

If yes, how many current sexual partners? _____

Same sex or opposite sex? □ Opposite □Same Have they experimented with same sex? □ Yes □ No

Please list all non-psychiatric medications: (over the counter or prescription):

Medication	Dosage	Frequency	Reason for taking

To your knowledge, has your adolescent ever abused non-prescription drugs? □ Yes □ No

If yes, which types and when? _____

To your knowledge, has your adolescent ever abused prescription drugs? □ Yes □ No

If yes, which types and when? _____

To your knowledge, has your adolescent ever abused alcohol? □ Yes □ No

If yes, which types and when? _____

To your knowledge, has your adolescent ever abused tobacco? □ Yes □ No

If yes, which types and when? _____

Has either parent had medical problems? □ Yes □ No

If yes, Please explain: _____

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COUNSELING AND PSYCHIATRIC INFORMATION

Has he/she had previous counseling? □ Yes □ No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

What were the results? _____

Has he/she ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, which type? _____

Please list any other disorders not already mentioned: _____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness?

□ Yes □ No If yes, which type? _____

To your knowledge, has your adolescent ever attempted to complete homicide? □ Yes □ No
If yes, When? _____ how? _____
What action was taken? _____
To your knowledge, has your adolescent ever attempted to complete suicide? □ Yes □ No
If yes, When? _____ how? _____
What action was taken? _____
To your knowledge, is there a history of suicide in your nuclear or extended family? □ Yes □ No
If yes, Who? _____ when? _____
To your knowledge, is your adolescent presently having thoughts of harming self or others? □ Yes □ No

If yes, explain _____

To your knowledge, is your adolescent presently self-harming by cutting themselves? □ Yes □ No

If yes, explain _____

Please list all psychiatric medications:

Medication	Dosage	Frequency	Reason for taking

Is your adolescent currently seeing any other medical physicians? € Yes € No

	Name	Address	Phone	* Initial for consent to contact
Physician/ pediatrician				
Psychiatrist				
Nutritionist/Dietitian				
School				

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Counselor				
Other				

** Will need to complete "Release of information" form in order to contact any of above*

FAMILY RELATIONSHIPS

If parents are separated or divorced, how old was the adolescent when this occurred? _____

How did the adolescent handle the separation or divorce? _____

_____

Are there difficulties within your marriage now? □ Yes □ No

If yes, do you think these difficulties are contributing to your adolescent's behavior? □ Yes □ No

If yes, please explain _____

_____

_____

To your knowledge, which family member is your adolescent the closest? _____

How does this adolescent get along with his/her brothers and/or sisters? _____

_____

Describe any special activities that you do with your adolescent and frequency of that activity: _____

_____

SCHOOL INFORMATION

Name of School: _____ Teacher: _____ Grade: _____

Please describe any positive or negative changes your adolescent is experiencing in school:

_____

_____

When did you first notice these changes? _____

What is your adolescent's attitude toward school? _____

What are his/her major complaints about school? _____

_____

Has he/she changed schools recently? □ Yes □ No If yes, when? _____

To your knowledge, does your adolescent get along with teachers and other students? □ Yes □ No

Please Explain: _____

_____

** If you want your adolescent's counselor to be able to talk to their teacher(s) or school counselor, you will need to complete a "Release of Information" form. Ask your adolescent's counselor.

REASON FOR SEEKING COUNSELING

What concerns or recent event have brought your adolescent to counseling today? _____

_____

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Please rate the severity of your adolescent's concerns on the following scale.
Check one: Mild Moderate Severe Totally Incapacitating

When did your adolescent's present issues begin to be a problem?_____

How are your adolescent's concerns affecting <u>you</u> personally? Please check all that apply:
☐ Home ☐ Dating Relationship ☐ Marriage ☐ Children ☐ Health ☐ Job ☐ Finances ☐ Extended Family
☐ Relationship with God ☐ Anger ☐ Stress ☐ Sadness/Depression ☐ Worry
Other: _____

BEHAVIOR CONCERNS

To the best of your knowledge, please check how often the following behaviors occur.

1) Loses temper easily	___Never	___Rarely	___Sometimes	___Frequently
2) Argues with adults	___Never	___Rarely	___Sometimes	___Frequently
3) Refuses adult's requests	___Never	___Rarely	___Sometimes	___Frequently
4) Deliberately annoys people	___Never	___ Rarely	___Sometimes	___Frequently
5) Blames others for own mistakes	___Never	___ Rarely	___Sometimes	___Frequently
6) Easily annoyed by others	___Never	___Rarely	___ Sometimes	___Frequently
7) Easily Angered/Recently	___Never	___Rarely	___ Sometimes	___Frequently
8) Spiteful/Vindictive	___Never	___Rarely	___ Sometimes	___Frequently
9) Defiant	___Never	___Rarely	___ Sometimes	___Frequently
10) Bullies/Teases others	___Never	___Rarely	___ Sometimes	___Frequently
11) Initiates fights	___Never	___Rarely	___ Sometimes	___Frequently
12) Uses a weapon	___Never	___Rarely	___ Sometimes	___Frequently
13) Physically cruel to people	___Never	___Rarely	___ Sometimes	___Frequently
14) Physically cruel to animals	___Never	___Rarely	___ Sometimes	___Frequently
15) Stealing	___Never	___Rarely	___ Sometimes	___Frequently
16) Forced sexual activity	___Never	___Rarely	___ Sometimes	___Frequently
17) Intentional arson	___Never	___Rarely	___ Sometimes	___Frequently
18) Burglary	___Never	___Rarely	___ Sometimes	___Frequently
19) "Cons" other people	___Never	___Rarely	___ Sometimes	___Frequently
20) Runs away from home	___Never	___Rarely	___ Sometimes	___Frequently
21) Truant at school	___Never	___Rarely	___Sometimes	___Frequently
22) Doesn't pay attention to details	___Never	___Rarely	___Sometimes	___Frequently
23) Several careless mistakes	___Never	___Rarely	___Sometimes	___Frequently
24) Does not listen when spoken to	___Never	___Rarely	___Sometimes	___Frequently
25) Doesn't finish chores/homework	___Never	___Rarely	___Sometimes	___Frequently
26) Difficulty organizing tasks	___Never	___Rarely	___Sometimes	___Frequently
27) Loses things	___Never	___Rarely	___Sometimes	___Frequently
28) Easily distracted	___Never	___Rarely	___Sometimes	___Frequently
29) Forgetful in daily activities	___Never	___Rarely	___Sometimes	___Frequently
30) Fidgety/squirmy	___Never	___Rarely	___Sometimes	___Frequently
31) Difficulty remaining seated	___Never	___Rarely	___Sometimes	___Frequently

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32) Runs/climbs around excessively ___Never ___Rarely ___Sometimes ___Frequently
33) Sexually Active ___Never ___Rarely ___Sometimes ___Frequently
34) Hyperactive ___Never ___Rarely ___Sometimes ___Frequently
35) Difficulty awaiting turn ___Never ___Rarely ___Sometimes ___Frequently

36) Interrupts others ___Never ___Rarely ___Sometimes ___Frequently
37) Problems pronouncing words ___Never ___Rarely ___Sometimes ___Frequently
38) Poor grades in school ___Never ___Rarely ___Sometimes ___Frequently
39) Expelled from school ___Never ___Rarely ___Sometimes ___Frequently
40) Drug abuse ___Never ___Rarely ___Sometimes ___Frequently

41) Alcohol consumption ___Never ___Rarely ___Sometimes ___Frequently
42) Depression ___Never ___Rarely ___Sometimes ___Frequently
43) Shy/avoidant/withdrawn ___Never ___Rarely ___Sometimes ___Frequently
44) Suicidal threats/attempts ___Never ___Rarely ___Sometimes ___Frequently
45) Fatigued ___Never ___Rarely ___Sometimes ___Frequently

46) Anxious/nervous ___Never ___Rarely ___Sometimes ___ Frequently
47) Excessive worry ___Never ___Rarely ___Sometimes ___Frequently
48) Sleep disturbance ___Never ___Rarely ___Sometimes ___Frequently
49) Panic attacks ___Never ___Rarely ___Sometimes ___Frequently
50) Mood shifts ___Never ___Rarely ___Sometimes ___Frequently

51) Feels fat ___Never ___Rarely ___Sometimes ___Frequently
52) Restricts food intake ___Never ___Rarely ___Sometimes ___Frequently
53) Purges food/Induce vomiting ___Never ___Rarely ___Sometimes ___Frequently
54) Eats an excessive amount of Food in short amount of time ___Never ___Rarely ___Sometimes ___Frequently
55) Exercises more than 2 hour a day ___Never ___Rarely ___Sometimes ___Frequently

56) Worries about what others think About appearance ___Never ___Rarely ___Sometimes ___Frequently

What are the top three behaviors that you would like to see changed?

1) _____ 2) _____

3) _____

STRENGTHS/WEAKNESSES

List his/her three greatest weaknesses or areas that you feel need improvement

1) _____ 2) _____

3) _____

List his/her three greatest strengths

1) _____ 2) _____

3) _____

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SOLUTIONS

What, if any solutions have you found that are helping your adolescent overcome his/her current issues?

_____

_____

DISCIPLINE

How do you currently discipline your adolescent?

_____

_____

SPIRITUALITY

Which denomination(s) does your family follow most closely? _____

Does your family read or talk about the bible regularly? □ Yes □ No

Does your adolescent attend church regularly? □ Yes □ No

If yes, which church does the adolescent attend? _____

What is the denomination of this church? _____

In your opinion, is spirituality important to your adolescent? □ Yes □ No

How does your adolescent respond to conversations about God and/or the Bible?

_____

Do you want your adolescent's counselor to discuss spiritual issues with your adolescent? □ Yes □ No

Referral information

How did you hear about Lunday Counseling Center?

□ Friend _____ □ Daycare _____
□ Church _____ □ Pastor/Minister _____
□ Doctor's office _____ □ School _____
□ Internet □ Other: _____

Can we thank them for the referral? _____ If so, make sure to put their name and contact info on space below. Thanks!

_____

Thank you so much for choosing Lunday Counseling Center. Please continue to pray for your adolescent as they continue in counseling. Counseling can sometimes be a difficult time, so I would ask that you pray for the guidance of the Holy Spirit to move in and through this process. Not only pray for your adolescent, but pray for me, that I will allow the Holy Spirit to be my mouthpiece and guide me in helping your adolescent. Pray for your family. This time may also be a trying time for them. If you have any questions, please do not hesitate to ask.