Teen History Form – Self Report

In order to help us get to know you better, please complete this form as completely and honestly as possible. Thank you!

Your Legal Name_____

Nickname_____

Date of Birth_____ **School**_____ **Grade**_____

Behavioral Excesses:
What do you do too often, too much, or at the wrong times that gets you in trouble? Please list all the behaviors and the consequences:

Behavioral Deficits:
What DON'T you do -- as often as you should, as much as you should, or when you are expected to – that gets you in trouble? Please list all the behaviors and the consequences:

Behavioral Assets:
What do you do when you want to get on your parent's good side? Your teacher's good side?

How often do you do these things?

Others Concerns:
What other concerns do you have about yourself or your family?

Name: **Nickname:** **Birthdate:**

Treatment Goals:
Based on what you've written down so far, what do you want to work on first, and how will we know when we've been successful?

Tell us About Your Family Relationships:

Name of PARENT	Biological parent	Legal parent or guardian	Has custody	Nights per week	Days per week
	Yes No	Yes No	Full Shares No		
	Yes No	Yes No	Full Shares No		
	Yes No	Yes No	Full Shares No		
	Yes No	Yes No	Full Shares No		

Siblings – Name	Age	Biological Relatedness	Lives with teen?	Explanation

Significant Others NOT living with you?				
Name	Age	Relationship	Grade/Job	Role in your life

Describe any past counseling that either you or any family member experienced. Use the back of this page if necessary and check here _____ if you do.

Does anyone in your family use any type of drug, tobacco, or alcohol? If yes, please describe:

Your Name: **Nickname:** **Date of Birth:**

Education History:

What school do you attend?
Address:

Phone: School Counselor's Name: Current Grade:

Are you in regular contact with the school? YES NO If yes, what's the nature of the communication?

Have you ever repeated a grade? If so which one(s)
Have you ever received Special Education services or been given an IEP/504 Plan? If yes, please summarize accommodations/recommendations:

Have you experienced any of the following problems at school or home? (Circle all that apply)

fighting	lack of friends	drug/alcohol use	detention
suspension	learning disabilities	poor attendance	poor grades
gang influence	incomplete homework	behavior problems	

Medical History:

What is the name of your doctor?
Address: Phone:

Date of your last medical examination:

Do you know if your mom had any problems during her pregnancy or delivery? If so, please describe them:

Your Name: **Nickname:** **Birthdate:**

Have you experienced any of the following medical problems? (Circle all that apply)

A serious accident	Hospitalization	Surgery
A head injury	High fever	Convulsions/seizures
Eye/ear problems	Meningitis	Hearing problems
Allergies	Loss of consciousness	Asthma
IBS/Crohn's Disease	Cutting/Self Injury	Other _____

Do you smoke cigarettes? YES NO

Are you sexually active? YES NO

Do you consume alcohol or illicit drugs? YES NO

Please list current medical problems or physical handicaps:

Please list medications that you take. If you are under the care of a psychiatrist, please complete the Release of Confidential Information form which will allow us to coordinate services with your psychiatrist.

Other History:

Have you ever experienced any type of abuse (physical, sexual, or verbal)? If so please describe:

Have you ever thought about hurting yourself or someone else?

Have you ever purposely hurt yourself or another? If yes to either question, please describe the situation:

Have you ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

What is currently stressful to/for you and/or your family?