

**Adolescent Form**  
**MidWest Center for Personal and Family Development**

(Note: All information on this form is considered strictly confidential  
within the guidelines of the clinic.)

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Sex M F  
Home Phone ( ) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Cell Phone ( ) \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_  
Current Job \_\_\_\_\_ Employer \_\_\_\_\_  
Work Phone ( ) \_\_\_\_\_

Why did you come? \_\_\_\_\_

How serious is this issue to you? (Rate 1-10, least serious = 1, most serious = 10) \_\_\_\_\_

**Background Information**

**Parents**

<u>Name</u>	<u>Age</u>	<u>Job / Retired</u>	<u>Physical / Emotional / Mental Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____

**Siblings (Brothers & Sisters)**

<u>Name</u>	<u>Age</u>	<u>Job</u>	<u>Physical / Emotional / Mental Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Children**

<u>Name</u>	<u>Age</u>	<u>Physical / Emotional / Mental Problems</u>
_____	_____	_____

Current living situation: Apartment [ ] House [ ]

Others living with you: Mother [ ] Father [ ] Significant other [ ] Children [ ] Grandparent [ ] Other [ ]

**Check the problems that trouble you in your family:**

- |   |   |
|---|---|
| <input type="checkbox"/> Dad or mom physically sick                   | <input type="checkbox"/> Brother / sister has emotional problems            |
| <input type="checkbox"/> Dad or mom has emotional problems            | <input type="checkbox"/> Brother / sister has problems with alcohol / drugs |
| <input type="checkbox"/> Dad or mom has trouble with alcohol or drugs | <input type="checkbox"/> Being physically abused at home                    |
| <input type="checkbox"/> Parents fighting                             | <input type="checkbox"/> Being sexually abused at home                      |
| <input type="checkbox"/> Parents divorcing                            | <input type="checkbox"/> Don't want to live at home                         |
| <input type="checkbox"/> Problems with stepparent                     | <input type="checkbox"/> Family fighting                                    |
| <input type="checkbox"/> Parents never home                           | <input type="checkbox"/> Don't have enough privacy                          |
| <input type="checkbox"/> Can't talk to mom or dad                     | <input type="checkbox"/> Too many household chores                          |
| <input type="checkbox"/> Mom or dad too strict                        | <input type="checkbox"/> Don't feel close to family                         |
| <input type="checkbox"/> Mom or dad expect too much                   | <input type="checkbox"/> Pet dying  |
| <input type="checkbox"/> Parents disapprove of friends                | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Parents disapprove of clothes, appearance    |   |
| <input type="checkbox"/> Parents disapprove of activities, music      |   |
| <input type="checkbox"/> Parents favor brothers or sisters            |   |
| <input type="checkbox"/> Ignored by parents                           |   |

## Issues

Suicidal thoughts  
 Suicidal attempts  
 Anxious, worried  
 Attitude issues  
 Bored  
 Brother / Sister problems  
 Confused  
 Count excessively  
 Cutting / Burning self  
 Depressed  
 Difficulty being alone

Disorganized  
 Distractible  
 Easily irritated  
 Fatigued  
 Focusing problems  
 Guilt feelings, shame  
 Hearing voices/hallucinations  
 Hyperactivity  
 Impulsive  
 Lonely  
 Memory/concentration problems  
 Mood swings  
 Motivation reduced/absent  
 Obsessive thoughts  
 Organize excessively  
 Panic attacks  
 Parent problems  
 Self-esteem low  
 Sexual identity concerns  
 Sexual problems  
 Sexually active  
 Sleep problems:  At times it takes me over 1/2 hour to get to sleep.  I wake up a lot at night.  
 Tearful  
 Unusual thoughts  
 Washing my hands a lot  
 Very concerned about germs

Anger problems  
 Aggressiveness  
 Alcohol use  
 Drug use  
 Eating habits  
 Restricting  Bingeing  Purging (making yourself throw up)  
 Laxative use for dieting  Overeating  
 Weight changes:  Increase  Decrease  
 Lying frequently  
 Perfectionistic  
 Shy, uneasy with others  
 Unassertive  
 Unwanted behavior, habits  
 Withdrawn

I worry about:

Being popular  
 Being left out  
 Everything  
 My parents  
 My brother / sister  
 My friends  
 Being sick a lot  
 School issues  
 Money problems  
 Being bullied  
 Other \_\_\_\_\_

I feel bad about:

People putting me down  
 Not having enough friends  
 Being excluded  
 My family  
 My grades  
 Myself  
 My appearance  
 The way I treat people  
 Not saying "No"  
 Other \_\_\_\_\_  
 I have trouble living up to other's expectations.  
 I get angry a lot.  
 I get in fights a lot.  
 I try to get my own way a lot.  
 I try to please everyone.  
 I think I'm right all the time.  
 I like to argue / compete with others.  
 Other people's opinion of me is very important.

**Medical History**

Medical concerns in the last year: \_\_\_\_\_  
 Chronic illnesses: \_\_\_\_\_  
 Surgeries: \_\_\_\_\_  
 Disabilities: \_\_\_\_\_  
 Current medications / reasons prescribed: \_\_\_\_\_

**Counseling**(current or previous)

Dates                      Clinic / Therapist                                      Reason

---



---

**Psychiatric Hospitalizations**(Dates / Hospital / Reason)

---

**Abuse Issues:**

Please indicate (✓) areas of **abuse that you have encountered**: (  Not applicable )

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

Please indicate (✓) areas of **abuse by you**: (  Not applicable )

	Past	Current
Physical abuse		
Sexual abuse		
Verbal abuse		
Emotional abuse		

**Alcohol / Drug Use**

Have there been any undesirable results of your chemical use? (low job or school performance, physical problems, relationship problems, DWI's)                                      [ ] Yes                      [ ] No

Have you ever been concerned about your own chemical use?                                      [ ] Yes                      [ ] No

Have others expressed concern about your chemical use?                                      [ ] Yes                      [ ] No

Have others who are close to you abused alcohol or drugs?                                      [ ] Yes                      [ ] No

If yes, who? (include family, friends) \_\_\_\_\_  
 \_\_\_\_\_

Have you ever attended a self-help group such as a support group, AA, NA, AlAnon, ACA?                      [ ] Yes                      [ ] No

Are you currently attending a self-help or support group?                                      [ ] Yes                      [ ] No

Name of group \_\_\_\_\_

Do you use nicotine? [ ] Yes [ ] No      \_\_\_\_\_ Cigarettes                      \_\_\_\_\_ Chewing tobacco

If yes, how much per day? \_\_\_\_\_

Describe your daily caffeine consumption (include coffee, tea, pop, chocolate):

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

**Social History**

How many close friends do you have at this time? \_\_\_\_\_

Approximately how many contacts do you have with these friends? (Check one)

Daily     3-5 times per week     Weekly     2 times per month     Monthly

Recreation, hobbies, interests: \_\_\_\_\_

**Check the problems that trouble you:**

- Being uncomfortable with people
- Being uncomfortable with the opposite sex
- Being criticized by others
- Not fitting in with peers
- Being suspicious of others
- Not having enough close friends
- Being taken advantage of by friends
- Feeling inferior
- Feeling pressured to do something I don't want to do
- Having problems with boyfriend / girlfriend
- Worrying about getting / being pregnant
- Not knowing enough about sex
- Worrying about sex
- Thinking about sex too often
- Being involved with pornography (movies, magazines, or computer)
- Worried about same-sex attraction
- Feeling used or being pushed into sex
- Sexual abuse
- Physical abuse
- Other \_\_\_\_\_

**Educational Issues**

Trouble with: grades \_\_\_\_\_ absences \_\_\_\_\_ skipping \_\_\_\_\_ teacher relationships \_\_\_\_\_

Learning disabilities \_\_\_\_\_

Other problems with school \_\_\_\_\_

**Job Issues**

List your last three (3) jobs outside the home:

Position	Duties	Dates (from-to)

**Religion**

List religious affiliation / spiritual involvements \_\_\_\_\_

Is religion important to you? \_\_\_\_\_

**Culture**

Ethnic background (American Indian, African American, German, Irish, etc.) \_\_\_\_\_

**CURRENT WELL-BEING**

1. At the present time, how upset or distressed have you been feeling?  
 ① Not at all distressed                      ④ Very distressed  
 ② Slightly distressed                         ⑤ Extremely distressed  
 ③ Pretty distressed
2. At the present time, how energetic and healthy have you been feeling?  
 ① Not at all energetic and healthy  
 ② Slightly energetic and healthy  
 ③ Pretty energetic and healthy  
 ④ Very energetic and healthy  
 ⑤ Extremely energetic and healthy
3. At the present time, how well do you feel that you are getting along emotionally and psychologically?  
 ① Quite poorly; I can barely  
 ② Fairly poorly; life is pretty tough for me at times.  
 ③ So-so; I manage to keep going with some effort  
 ④ Fairly well; I have my ups and downs  
 ⑤ Quite well; I have no important complaints  
 ⑥ Very well; much the way I would like to
4. At the present time, how satisfied have you been feeling with your life?  
 ① Not at all satisfied.                      ④ Very satisfied  
 ② Slightly satisfied.                         ⑤ Extremely satisfied.  
 ③ Pretty satisfied

**CURRENT LIFE FUNCTIONING**

Please rate how much difficulty you are having in the following areas of your life:

	No Difficulty	Some Difficulty	A Lot of Difficulty	Extreme Difficulty
1. Ability to perform routine tasks.				
2. Ability to maintain my personal appearance.				
3. Ability to concentrate and complete tasks.				
4. Participation in physical activities.				
5. Ability to function as an independent person.				
6. Ability to manage my finances.				
7. Being the kind of person I would like to be.				
8. Maintaining good health habits				
9. Interactions with people at work.				
10. Performance at work or school.				
11. Developing or managing my career.				
12. Creative activities.				
13. Attending work or school or getting there on time.				
14. Interactions with my spouse/romantic partner.				
15. Interaction with my parents.				
16. Interaction with my brothers or sisters.				
17. Ability to form or sustain intimate relationships.				
18. Enjoyment of sexual activities.				
19. Carrying out family responsibilities.				
20. Interactions with friends.				
21. Participation in social activities.				
22. Planning and enjoying leisure time activities.				
23. Ability to control myself and stay out of trouble.				
24. Ability to be comfortable with people.				