Quest Family Therapy
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Adolescent Client Information Sheet

Please provide the following information and answer the questions below. Information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Client's Full Name: _____ Date:_____

Address: _____

City & State: _____ Zip: _____

Parent/ Guardian Name(s): _____

Home Phone: (_____)_____ May I leave a message? ☐Yes ☐No

Cell/Other Phone: (_____) _____ May I leave a message? ☐Yes ☐No

E-mail: _____ May I email you? ☐Yes ☐No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: ____/____/_____ Age: _____ Gender _____

Ethnicity: _____

Are you currently in school? ☐ Yes ☐ No

If yes, tell me more about your school:

School Name:_____

Your grade or year: _____ School Location : _____

Do you enjoy school? Is there anything stressful about school (either the work or people)?

_____

_____

_____

Are you currently employed? ☐ Yes ☐ No

If yes, what is your current employment situation?

Employer:_____

Position: _____ For how long?_____

Do you enjoy your work? Is there anything stressful about your current work?

sa_____

_____

Do you consider yourself to be spiritual or religious? ☐No ☐Yes

If yes, describe your faith and/or religious or spiritual affiliation:

_____

Relationship status: ☐ Single ☐ Dating ☐ Have an important person/s ☐ Other:_____

How would you describe your sexual orientation? _____

Significant other's name(s) age, sex and how long together: _____

_____

Do you have any siblings? ☐Yes ☐No

Names and ages of all siblings living with you:_____

_____

Names and ages of all siblings not living with you:_____

_____

Medical and Health History

List any allergies you have:_____

Do you have a regular doctor you see? ☐Yes ☐No

If yes, how comfortable are you with your doctor? _____

1. Are you currently taking any prescription medication? ☐Yes ☐No

If yes, please list all current medications, dosages and frequencies:

_____

_____

2. How would you rate your current physical health? (please check one):

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list all current or past health problems, and any major operations:

_____

_____

_____

3. How would you rate your current sleeping habits? (please check one):

☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please list any specific sleep problems you are currently experiencing:

_____

_____

_____

4. How many times per week do you generally exercise?_____

What types of exercise do you participate in?_____

_____

5. Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

6. Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ No

☐ Yes: List all therapists you have seen, and how old you were when you saw them:

_____

_____

_____

7. Have you ever been in substance abuse treatment or had to stay in the hospital for more than a day?

☐ No

☐ Yes: List all substance abuse treatment or hospital stays and how old you were at the time:

_____

_____

_____

8. How often do you engage in recreational drug use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Please indicate which of these substances you currently use and how often:

How often? (If none, leave blank)

_____ ☐ Cigarettes

_____ ☐ Alcohol

_____ ☐ Pills not prescribed for me

_____ ☐ Marijuana

_____ ☐ Cocaine or crack

_____ ☐ LSD

_____ ☐ Heroin

_____ ☐ Other (please list): _____

9. Are you currently experiencing any chronic pain?

☐ No

☐ Yes: (please describe): _____

10. Do you currently have any physical or learning disabilities that you know of?

☐ No

☐ Yes: (please describe): _____

What significant life changes or stressful events have you experienced recently:

_____

_____

_____

_____

_____

What kind of problem(s) brings you to seek counseling at this time? If someone else, like a parent has insisted you come see me, what do you think they consider the problem? If you disagree with them, then what is the real issue, from your perspective?

_____

_____

_____

_____

Please indicate if you are having any of the following problems now, or if you had them in the past:

Now	In the Past	
☐	☐	Difficulty falling asleep or staying asleep
☐	☐	Sleeping too much
☐	☐	Change in appetite/weight loss/weight gain
☐	☐	Frequent crying
☐	☐	Panic attacks or anxiety attacks
☐	☐	Thoughts of killing or hurting myself
☐	☐	Attempts to kill or hurt myself
☐	☐	Problems concentrating
☐	☐	Problems remembering things
☐	☐	Periods of daily sadness lasting more than two weeks
☐	☐	I startle easily
☐	☐	Periods of time where I seem to need very little sleep
☐	☐	Often feel as if I am running like a motor
☐	☐	Can't stop remembering upsetting past events
☐	☐	Difficulty controlling my temper
☐	☐	I physically hurt other people
☐	☐	I break things sometimes
☐	☐	Other (please list): _____

_____

Now	In the Past	
☐	☐	I worry a lot
☐	☐	If you are sexually active, little or no interest in sex
☐	☐	I feel tired almost every day
☐	☐	Feelings of unreality
☐	☐	Made myself throw up in order to lose weight
☐	☐	Used laxatives or exercised excessively to lose weight
☐	☐	I have thoughts that I can't get out of my head
☐	☐	I engage in repetitive behavior
☐	☐	I sometimes hear or see things that others don't
☐	☐	I often feel like I am an outsider
☐	☐	Avoid particular locations or situations
☐	☐	Worry that something is wrong with my body
☐	☐	Frequent arguments with the people I live with
☐	☐	I hear voices inside my head

Continued on the next page

Family and Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

If yes, list family member:

_____ ☐ Yes ☐ No ADHD

_____ ☐ Yes ☐ No Alcohol/Substance Abuse

_____ ☐ Yes ☐ No Anxiety

_____ ☐ Yes ☐ No Bipolar Disorder

_____ ☐ Yes ☐ No Depression

_____ ☐ Yes ☐ No Domestic Violence

_____ ☐ Yes ☐ No Eating Disorders

_____ ☐ Yes ☐ No Obesity

_____ ☐ Yes ☐ No Obsessive Compulsive Behavior

_____ ☐ Yes ☐ No Phobias/Panic

_____ ☐ Yes ☐ No Schizophrenia

_____ ☐ Yes ☐ No Suicide Attempts

What do you consider to be some of your strengths?

_____

_____

_____

_____

What do you consider to be some of your weaknesses?

_____

_____

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

_____

Who can I contact in case of emergency?

Name: _____ Phone (_____)_____

Relationship _____

I hereby consent for Shawn V. Giammattei, Ph.D. to provide me with evaluation and treatment.

_____ _____

Signature Date

Thank you