Quest Family Therapy

Shawn V. Giammattei, PhD
Licensed Clinical Psychologist
CA License # PSY 22570

1049 4th Street, Suite G
Santa Rosa, CA 95404

2014 10th Avenue
San Francisco, CA 94116

Phone: 415-722-7134
Fax: 415-729-1670
E-Mail: drshawn@questfamilies.com
Web: www.questfamilies.com

EIN: 27-1002144

Adolescent Client Information Sheet

Please provide the following information and answer the questions below. Please note: 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: ____________________

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? ☐ No ☐ Yes

If yes, tell me more about your school.

School Name:____

Grade or year: ____ School Location ___________________

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

____

____

Are you currently employed? ☐ No ☐ Yes

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?

____

____

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

(Describe)________________________

How would you describe your sexual orientation?

____

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

____

Do you have any siblings? ☐ No ☐ Yes

Names and ages of all siblings living with you:____

____

Names and ages of all siblings *not* living with you:____

____

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

Medical and Health History

Name:____ Date:_____________________

List any allergies you have:______________________________________ None______

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

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

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

If yes, please list all current medications and dosages:

Name of Medication	**Dosage**	**Name of Prescribing Doctor**	**When did you start taking it?**

2. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

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

Current	**Past**

3. How would you rate your current sleeping habits? (please circle)

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 to you participate in: ________________________________

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

____

6. Have you ever 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 recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

Please indicate which of these substances you currently use:

Substance	**Amount used**	**How often?**
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, or if you had them in the past:

	I have this now	**I had it in the past**
Difficulty falling asleep or staying asleep		
Sleeping too much		
Change in appetite, weight loss, or 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		
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 other's 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		

Other (please list): ______________________________

FAMILY 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.).

	Please Circle	List Family Member
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	yes/no	

What do you consider to be some of your strengths?

What do you consider to be some of your weakness?

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

Signature Date