FLETCHERS
Counseling
10000 N. Central Expy. Suite 457
Dallas, TX 75231
214-523-9627

Confidential Adolescent Information Form

Name: _____ Today's Date: _____

Nickname/Name you want to be called: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Age: _____ Gender (M/F): _____

Home Phone: _____ Cell Phone: _____

School: _____ Grade: _____

Present Living Arrangement:

☐ Parents ☐ One Parent ☐ Grandparent ☐ Guardian ☐ Other_____

Parent's/Guardian's Name and relationship to you:

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Parent's/Guardian's Phone Number: _____ _____

Are you employed? ☐ Yes ☐ No Where? _____

Do you participate in extracurricular activities? ☐ Yes ☐ No

If yes, what are they?

What is your current average grade in each of the following subjects?

English _____ Math _____ Science _____ History _____

Please list other classes you are presently taking and your current average

_____

Did you participate in the decision to start counseling? ☐ Yes ☐No

Have you ever been in counseling before? ☐ Yes ☐No If yes, when? _____

Please describe what brings you to counseling at this time. _____

_____

_____

What have you already done to deal with the difficulties? _____

_____

_____

What do you hope to gain through counseling? _____

_____

_____

How would you rate your current physical health? ☐ Excellent ☐ Good ☐Fair ☐ Poor

Are you currently experiencing any physical problems (e.g~ headaches, body aches)

☐ Yes ☐ No

If yes, please explain: _____

_____

List any serious or chronic illnesses, operations, or traumatic accidents you have had:

List any medications and dosages you are taking:

Medication	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

What are your biggest strengths? _____

_____

_____

Do you exercise? ☐ Yes ☐ No

If yes, how many times per week? _____ For how long? _____

Do you smoke cigarettes: ☐ Yes ☐ No

If yes, how many per day? _____

Do you consume alcohol? ☐ Yes ☐ No

If yes, how many drinks per day? _____ week? _____

Do you take any recreational drugs? ☐ Yes ☐ No

What kind? _____

How many times per day? _____ week? _____

PROBLEM CHECKLIST

Please rate each issue with a number 1, 2, or 3

1 = Major Problem 2 = Sometimes a problem 3 = Never a problem

_____ Feeling accepted by my peers

_____ Learning how to trust others

_____ Feeling bad about the way I look/my body

_____ Getting along with my parents or other family members

_____ Getting a clear sense of what I value

_____ Worrying about whether I'm normal

_____ Dealing with sexual feelings and/or problems

_____ Excessive worry or anxiety

_____ Trying to decide on a career

_____ Never eating/eating too much and vomiting to control weight

_____ Dealing with my alcohol or drug abuse

_____ Dealing with problems at school

_____ Dealing with how I feel about myself

_____ Thinking about killing myself

_____ Wanting to hurt someone else

_____ Not being able to sleep at night

Are there any other problems or concerns you would like to address? _____

_____