

## Pensacola Bay Baptist Association

### Counseling Ministry

9999 Chemstrand Road, Pensacola, FL 32514

850-471-3430 www.pbbassociation.com

— **Rachael Croley, Licensed Clinical Social Worker**  
**License #SW 6156**  
**Director of Counseling Ministries**

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**Registered Mental Health – Intern**  
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— **Michael Myers, Counseling Intern**

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### Welcome to our Office!

Thank you for choosing us to help you with your counseling needs. We want to take this opportunity to explain policies and procedures of the Practice at the Pensacola Bay Baptist Association.

### APPOINTMENTS:

We consider our appointments very important. Counseling is a commitment to work together. We pray you will also share in this commitment. Please do not miss sessions if possible. Therapy sessions are 50 minutes. Fee and cancellation policy are described under “Financial Responsibility” below.

### LIMITS OF CONFIDENTIALITY:

Information discussion in the counseling setting is held confidential and will not be shared without the written permission of the client except under the following conditions.

- ! The client threatens to harm self or another person.
- ! The client reports the abuse of a child, a person who is elderly, or a person who is disabled.
- ! The client reports sexual exploitation by a counselor, therapist or other mental health professional.
- ! Your counseling records by a state or federal court of law if legal action is taken against you.

### RECORD MAINTENANCE AND EMERGENCY SITUATIONS:

Psychotherapy records must be maintained in my possession according to state laws. Copies of your records or a summary of such records will be provided and may be conditioned upon your payment of the reasonable cost of reproduction and time to prepare such records.

If you should experience an emotional or behavioral crisis and I cannot be reached immediately by telephone, you and your family members are instructed to contact the “HELP” Line at 438-1617, dial 911, or present yourself at the nearest hospital emergency room.

### FINANCIAL RESPONSIBILITY:

You are responsible for full payment of all services regardless of insurance coverage. A sliding fee scale is available for those who financially qualify. Verification is necessary when using sliding fee scale. At the completion of each session you will receive a receipt of service that is appropriate to file with your insurance for reimbursement. Please make checks payable to **PBBA (Pensacola Bay Baptist Association)**. A minimum return check fee of \$7 will be charged. Fees are as follows:

<b>First Session:</b>	<b>\$90.00 (50 minutes)</b>	<b>AGREED FEE AMOUNT \$ _____</b>
<b>Individual Session:</b>	<b>\$80.00 (50 minutes)</b>	<b>BASED ON SLIDING FEE SCALE</b>
<b>Family/Couple Session:</b>	<b>\$90.00 (50 minutes)</b>	<b>*BRING INCOME VERIFICATION TO RECEIVE SLIDING FEE</b>

We are now accepting the following major credit cards! MasterCard, Visa, and Discover

No fees will be charged for appointments cancelled 24 hours or more prior to appointment date and time. Half fees will be charged for no shows or last minute cancellations. Voice mail is available 24 hours a day, and messages are checked daily.

I have read the Office, Financial and Confidential Policies outlined in this document and agree to comply with these policies. I agree to the limits of confidentiality.

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Counselor's Signature

\_\_\_\_\_  
Date

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### FACE SHEET

1. Patient Name: \_\_\_\_\_  
(Last) (First) (MI) (Nickname)
2. Address: \_\_\_\_\_ 3. Home Phone: ( ) \_\_\_\_\_  
(City) (State) (Zip)
4. Work Phone: ( ) \_\_\_\_\_ 5. Social Security #: \_\_\_\_\_ 6. Birth date: \_\_\_\_\_ Age: \_\_\_\_\_
7. Sex: M F 8. Marital Status: S M D W 9. Employer: \_\_\_\_\_
10. Occupation: \_\_\_\_\_ 11. Student/School: \_\_\_\_\_
12. If dependent child, are custodial parents: \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Other
13. Religion \_\_\_\_\_ 14. REFERRED BY: \_\_\_\_\_
15. IN CASE OF EMERGENCY NOTIFY:  
Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone ( ) \_\_\_\_\_

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### FINANCIALLY RESPONSIBLE PARTY

1. Guarantor Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
(Last) (First) (MI)
2. Guarantor Address \_\_\_\_\_  
(City) (State) (Zip)
3. Guarantor Relationship to Patient (circle one): Spouse Mother Father Sibling Other Relative Friend
4. Home Phone: ( ) \_\_\_\_\_ 5. Social Security # \_\_\_\_\_ 6. Drivers License # \_\_\_\_\_
7. Previous Address (if less than 3 yrs. at current address) \_\_\_\_\_
8. Guarantor's Employer: \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Occupation \_\_\_\_\_
9. Spouse Name: \_\_\_\_\_ 10. Spouse Work Phone: ( ) \_\_\_\_\_

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### INSURANCE

1. Primary Insurance Co. Name: \_\_\_\_\_ Phone :( ) \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_
2. Subscriber's Name: \_\_\_\_\_ Relationship to Patient: Self Spouse Parent Other  
Employer: \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Occupation \_\_\_\_\_  
Birth date: \_\_\_\_\_ Group ID# \_\_\_\_\_ Social Security# \_\_\_\_\_

I understand I am financially responsible for all service rendered to me or the client and agree to pay charges for such services present and future at the time services are provided.

Client Signature \_\_\_\_\_ Date: \_\_\_\_\_

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### Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist names below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or any procedures provided by this therapist. I acknowledge that I have been informed counseling can be a painful process. I have had all my questions answered fully.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court system.)

I know I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show, I will be charged for the missed appointment.

I am aware that an agent of my insurance company or third-party payer may be given information about the type(s), cost(s) and providers of any service or treatments I receive. I understand payment for service is due at the end of each session, and I am responsible for full payment regardless of insurance coverage.

My signature below shows I understand and agree with all of these statements.

\_\_\_\_\_  
Signature of client (parent, guardian  
or other representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Signature of client (parent, guardian  
or other representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian or other representative.) My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent and willing consent.

\_\_\_\_\_  
Therapist

\_\_\_\_\_  
Date

**Pensacola Bay Baptist Association**  
**Counseling Ministry**  
9999 Chemstrand Rd.  
Pensacola, FL 32514

## **CHILD AND ADOLESCENT CONSENT FOR TREATMENT**

PATIENT: \_\_\_\_\_ Birth date: \_\_\_\_\_

I certify that I am the father/ mother/ guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I hereby give my authorization and consent for the above named child/adolescent to receive outpatient assessment/therapy from the Counseling Ministry affiliated with Pensacola Bay Baptist Association.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**Child and Adolescent Assessment  
PARENT QUESTIONNAIRE**

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Age

**PREGNANCY PROBLEMS**

Please check the following for the mother of this child:

- |  | <b>TRUE</b> | <b>NOT TRUE</b> | <b>DON'T KNOW</b> |
|--|-------------|-----------------|-------------------|
| 1. Had bleeding during the first 3 month   | _____       | _____           | _____             |
| 2. Had bleeding during the second 3 months   | _____       | _____           | _____             |
| 3. Had bleeding during the last 3 months   | _____       | _____           | _____             |
| 4. Gained less than 15 pounds, specify:  | _____       | _____           | _____             |
| 5. Gained more than 30 pounds, specify:  | _____       | _____           | _____             |
| 6. Had pre-eclampsia or toxemia  | _____       | _____           | _____             |
| 7. Had to take medications; list:  | _____       | _____           | _____             |
| 8. Took narcotic drugs; list:  | _____       | _____           | _____             |
| 9. Drank alcohol; amount:  | _____       | _____           | _____             |
| 10. Had previous miscarriage; number:  | _____       | _____           | _____             |
| 11. Had premature baby(ies)  | _____       | _____           | _____             |
| 12. Smoked 1 pack or more of cigarettes daily  | _____       | _____           | _____             |
| 13. Labor lasted less than 2 hours   | _____       | _____           | _____             |
| 14. Labor lasted more than 12 hours  | _____       | _____           | _____             |
| 15. Had a difficult labor  | _____       | _____           | _____             |
| 16. Was put to sleep for delivery  | _____       | _____           | _____             |
| 17. Was given medication for labor; specify:   | _____       | _____           | _____             |
| 18. Delivery was normal  | _____       | _____           | _____             |
| 19. Delivery was breech, caesarian, forceps, induced   | _____       | _____           | _____             |
| 20. How was the mother's health during the pregnancy of this child/adolescent? ___good ___ fair ___don't know            |             |                 |                   |
| 21. How old was the mother when this child/adolescent was born? _____  |             |                 |                   |
| 22. Was this child/adolescent born on schedule? ___8 mths. or earlier ___term (8-10 mths) ___after 10 mths ___don't know |             |                 |                   |
| 23. What was this child's adolescent's birth weight? ___pounds ___ounces   |             |                 |                   |
| 24. Is this child/adolescent adopted? ___yes ___no If yes, at what age? _____  |             |                 |                   |
| 25. Number of previous pregnancies: _____  |             |                 |                   |
| 26. Number of living children: _____   |             |                 |                   |

**NEWBORN INFANT PROBLEMS**

**(First month of life)**

- |   | <b>TRUE</b> | <b>NOT TRUE</b> | <b>DON'T KNOW</b> |
|---|-------------|-----------------|-------------------|
| 1. Born with cord around neck           | _____       | _____           | _____             |
| 2. Injured during birth                 | _____       | _____           | _____             |
| 3. Had trouble breathing                | _____       | _____           | _____             |
| 4. Got yellow (jaundiced)               | _____       | _____           | _____             |
| 5. Turned blue (cyanosis)               | _____       | _____           | _____             |
| 6. Was a twin or triplet                | _____       | _____           | _____             |
| 7. Had an infection                     | _____       | _____           | _____             |
| 8. Was given medications, specify:      | _____       | _____           | _____             |
| 9. Had seizures                         | _____       | _____           | _____             |
| 10. Needed oxygen                       | _____       | _____           | _____             |
| 11. Was in hospital more than five days | _____       | _____           | _____             |
| 12. Born with a heart defect            | _____       | _____           | _____             |
| 13. Born with other defect(s), specify: | _____       | _____           | _____             |
| 14. Had trouble sucking                 | _____       | _____           | _____             |
| 15. Had skin problems                   | _____       | _____           | _____             |
| 16. Colic                               | _____       | _____           | _____             |
| 17. Sleep problems                      | _____       | _____           | _____             |

**DEVELOPMENTAL FACTORS**

When did your child/adolescent do the following:  
(If you cannot recall the age, write either early, normal, or late.)

	Never	0-3	4-6	7-12	13-18	19-24	2-3	3-4	4-5	5-7	Since
		mo.	mo.	mo.	mo.	mo.	yrs.	yrs.	yrs.	yrs.	yrs.
1. Hold up head											
2. Roll front to back											
3. Sit alone											
4. Crawl											
5. Walk alone											
6. Speak single words (not mama or dada)											
7. String two or more words together											
8. Toilet trained (bladder control)											
9. Toilet trained (bowel control)											
10. Attend pre-school											
11. Attend kindergarten											
12. Have difficulty separating from parents											
13. Thumb-sucking											
14. Fear of animals, darkness, etc.											
15. Nightmares											
16. Hurt self, others, animals											
17. Play with fire											
18. Run away											
19. Temper tantrums											
20. Open masturbation											
21. Afraid to go to school											
22. Behavior problems at school											
23. Academic problems at school											

- How would you rate the activity level of the child/adolescent as an infant/toddler?  
 very active    active    average    less active    not active
- Approximately how long did toilet training take from onset to completion?  
 less than 1 month    1-2 months    2-3 months    more than 3 months

**MEDICAL HISTORY**

Please rate your child/adolescent in each of the following areas:

	GOOD	FAIR	POOR
1. Health			
2. Hearing			
3. Vision			
4. Gross motor coordination			
5. Fine motor coordination			
6. Speech articulation			

- Has your child/adolescent had any chronic health problems (e.g. asthma, diabetes, heart condition)?  No    Yes  
 If yes: \_\_\_\_\_
- When was the onset of any chronic illness?  Birth    0-1 yr    1-2 yrs    2-3 yrs    3-4 yrs  
 Over 4 yrs
- Check which of the following illness this child/adolescent has had:  
 mumps    chicken pox    measles    whooping cough    scarlet fever    pneumonia  
 encephalitis    otitis media    lead poisoning    seizures    other
- Check if this child/adolescent has had any accidents resulting in the following:  
 broken bones    head injury    stomach pumped    lost teeth    severe lacerations  
 severe bruises    eye injury    stitches
- How many accidents has this child/adolescent had?  one    2-3    4-7    8-12    over 12
- Check if this child/adolescent has had surgery for any of the following conditions:  
 tonsillitis    appendicitis    leg or arm    burns    adenoids    digestive disorder

\_\_\_ eye, ear, nose or throat \_\_\_ hernia \_\_\_ urinary tract  
\_\_\_ other \_\_\_\_\_

13. How many times? \_\_\_ once \_\_\_ twice \_\_\_ 3-5 times \_\_\_ 6-8 times \_\_\_ 8 times or more  
14. How long was your child/adolescent in the hospital? \_\_\_ one day \_\_\_ 2-3 days \_\_\_ 4-6 days \_\_\_ 1-4 weeks \_\_\_ 1-2 month

Please check the following problems:

- |  | YES | NO  | DON'T KNOW |
|--|-----|-----|------------|
| 15. Suspicion of alcohol or drug use   | ___ | ___ | ___        |
| 16. History of physical/sexual abuse   | ___ | ___ | ___        |
| 17. Sleeping problems  | ___ | ___ | ___        |
| 18. Is this child/adolescent a restless sleeper  | ___ | ___ | ___        |
| 19. Does this child/adolescent have bladder control problems: At night? ___ Yes ___ No |     |     |            |
| If yes, how often? _____   |     |     |            |
| During the day? ___ Yes ___ No   |     |     |            |
| If yes, how often? _____   |     |     |            |
| If yes, did this child/adolescent ever have bladder control? ___ Yes ___ No            |     |     |            |
| If yes, explain: _____   |     |     |            |

20. Did this child/adolescent have bowel control problems: At night? \_\_\_ Yes \_\_\_ No  
If yes, how often? \_\_\_\_\_  
    During the day? \_\_\_ Yes \_\_\_ No If yes, how often? \_\_\_\_\_  
    If yes, did the child/adolescent ever have bowel control? \_\_\_ Yes \_\_\_ No  
If yes, explain: \_\_\_\_\_

21. Does this child/adolescent have any appetite control problems? \_\_\_ overeats \_\_\_ average \_\_\_ under-eats

### SEXUAL MATURATION HISTORY

Did you notice any unusual behavior in your child/adolescent (i.e. cross dressing, excessive or public masturbation, sexual offenses, promiscuity, etc)? \_\_\_\_\_

At what age did your child/adolescent show adult body development? \_\_\_\_\_

At what age did your child/adolescent begin menstruating? \_\_\_\_\_

Was your child/adolescent prepared for these changes? \_\_\_\_\_

Were there any special problems with the onset of menstruation? \_\_\_\_\_

Does your child/adolescent appear comfortable with the opposite sex? \_\_\_ Yes \_\_\_ No

Is your child/adolescent sexually active? \_\_\_ Yes \_\_\_ No

Have there been any pregnancies or abortions? \_\_\_ Yes \_\_\_ No

### TREATMENT HISTORY

1. Check the medications your child/adolescent has been prescribed and write in the length of time they were on medication:

MEDICATION	DURATION
Ritalin	
Tranquilizers	
Dexedrine	
Cylert	
Other	

2. Has this child adolescent ever had any of the following forms of psychological treatment? If so, how long did it last and when was it:

    Individual psychotherapy \_\_\_\_\_

    Group psychotherapy \_\_\_\_\_

    Family therapy with child \_\_\_\_\_

    Inpatient evaluation \_\_\_\_\_

Day hospital treatment \_\_\_\_\_

Residential treatment \_\_\_\_\_

**FAMILY HISTORY**

Check if there is any history of any of the following in the family:

- 1.  Learning Disabilities \_\_\_\_\_
- 2.  Mental Retardation
- 3.  Psychosis or Schizophrenia
- 4.  Depression
- 5.  Anxiety Disorder
- 6.  Tics or Tourettes
- 7.  Alcohol or Drug Abuse
- 8.  Arrests
- 9.  Physical or Sexual Abuse
- 10.  Hyperactivity
- 11.  Birth Defects
- 12.  Diabetes
- 13.  Nervous Breakdown

**LIVING SITUATION**

- 1. Last living situation of child/adolescent: (Circle One)
  - a. Both parent's home
  - b. One parent's home
  - c. Legal guardian's home
  - d. Relative's home
  - e. Friend's home
  - f. Other \_\_\_\_\_
  
- 2. Primary living situation for past year: (Circle one)
  - a. Both parent's home
  - b. One parent's home
  - c. Legal guardian's home
  - d. Relative's home
  - e. Friend's home
  - f. Other \_\_\_\_\_

Please describe the family home:  House  Apartment  Condo

Number of rooms  Number of bathrooms  Number of bedrooms

Please indicate who sleeps in each bedroom \_\_\_\_\_

Please describe your neighborhood \_\_\_\_\_

Who has taken care of the patient most of their life? \_\_\_\_\_

Who is the primary disciplinarian in the family? \_\_\_\_\_

Are they:  strict  lenient

Do parents agree on the issues of parenting, rules and discipline?  always  usually  sometimes  rarely

Have there been or are there currently any major changes or stresses in the family where the child was raised?

Yes  No If yes, please check all the following that applies:

	<u>In past</u>	<u>Current (6 months or less)</u>
Financial problems	_____	_____
Frequent moves	_____	_____
Job changes	_____	_____
Drinking/drug problems	_____	_____
Arguments between parents	_____	_____
Separation or divorce of parents	_____	_____
Remarriage of parent(s)	_____	_____

Separation from sibling(s)	_____	_____
Separation from other family member	_____	_____
Frequent physical punishment	_____	_____
Physical confrontations between parents	_____	_____
Separation from significant non-family member	_____	_____
Mental illness in family	_____	_____
Physical illness in family	_____	_____
Psychiatric hospitalization of a parent	_____	_____
Death in the family	_____	_____
Sexual promiscuity of incestuous behavior in family	_____	_____
Family feels isolated	_____	_____
Other _____	_____	_____

How has the family been changed by the patient's problem(s)? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are the family's expectations of treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What does the family see as their role in treatment? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are the family's strengths? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are the family's weaknesses? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHOOL HISTORY**

1. Please summarize the child/adolescent's progress (e.g. academic, social, testing) within each of the following grade levels:

Preschool: \_\_\_\_\_

\_\_\_\_\_

Kindergarten: \_\_\_\_\_

\_\_\_\_\_

Grades 1-3: \_\_\_\_\_

\_\_\_\_\_

Grades 4-6: \_\_\_\_\_

\_\_\_\_\_

Grades 7-12: \_\_\_\_\_

\_\_\_\_\_

2. Has the child/adolescent ever been in any type of special educational program, and if so, how long?

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

Behavioral/emotional disorders class \_\_\_\_\_  
Helping teacher/content mastery \_\_\_\_\_  
Speech and language therapy \_\_\_\_\_  
Other \_\_\_\_\_

3. Check any of the following that apply with this child/adolescent at school:

	In what grades
Oppositional_____	_____
Disrupt class_____	_____
Inattentive_____	_____
Refuse to go to school_____	_____
Fail to turn in work_____	_____
Disorganized_____	_____
Detention_____	_____
In-school suspension_____	_____
Out-of-school suspension_____	_____
Expelled from school_____	_____

4. Have any additional instructional modifications been attempted?  
 None  behavior modification program  daily/weekly report card  
 other \_\_\_\_\_

5. Has this child/adolescent had any educational testing?  Yes  No  
If yes, what \_\_\_\_\_ (and bring it with you to the appt.)

**SOCIAL HISTORY**

1. How does this child/adolescent get along with his/her brothers/sisters?  
 Doesn't have any  better than average  average  worse than average
2. How easily does this child/adolescent make friends?  Easier than average  average  worse than average
3. On the average, how long does your child/adolescent keep friendships?  less than 6 mths  6 mts-1 year  
 more than 1 year
4. Is your child/adolescent able to form close relationships?  Yes  No
5. Personality traits of your child/adolescent:  withdrawn  anxious  outgoing  
 other \_\_\_\_\_
6. How would you describe a typical day for your child/adolescent: \_\_\_\_\_  
\_\_\_\_\_

**CURRENT BEHAVIORAL CONCERNS**

1. What are your primary concerns at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. What are other (related concerns)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. What strategies have been used to address these problems? (Check those that apply and circle those that have been successful):  
 Verbal reprimands  -time out (isolation)  removal of privileges  rewards  
 physical punishment  giving in to the child  avoiding the child
4. On the average, what percentage of the time does your child/adolescent comply with initial commands?  
 0-20%  20-40%  60-80%  80-100%
5. On the average what percentage of the time does your child/adolescent eventually comply with commands?

\_\_\_0-20% \_\_\_20-40% \_\_\_60-80% \_\_\_80-100%

6. To what extent are you and your spouse consistent with respect to disciplinary strategies?

\_\_\_Most of the time \_\_\_some of the time \_\_\_none of the time

What would you like to change about your family? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is there anything else about the family that we should know in order to be more helpful? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please mark any of the statements below which apply to your family.

	Yes	No
Our family is warm and loving	_____	_____
People are always fighting	_____	_____
Everyone goes his or her own separate way	_____	_____
People say what is on their mind	_____	_____

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Pensacola Bay Baptist Association**  
**Counseling Ministry**  
9999 Chemstrand Rd.  
Pensacola, FL 32514

**Adolescent Questionnaire**

*Confidential*

NOTE: THIS FORM IS OPTIONAL! Any information you give me would help me to know more about you (rather than just what your parents say about you). If you would rather not, please feel free to answer only part or none of the questions. Please DO NOT show your parents your answers.

Name \_\_\_\_\_

Age \_\_\_\_\_

Whose idea was it for you to come here?

mine

parent(s)

other \_\_\_\_\_

How do you feel about being here?

It's fine with me

I don't care either way

I'm against it

What would you say is the reason you are here? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**School**

What school do you go to? \_\_\_\_\_

Anything you particularly like about it? \_\_\_\_\_

Anything you particularly don't like? \_\_\_\_\_

What activities (if any) are you in at school (such as sports, music, etc.)? \_\_\_\_\_

\_\_\_\_\_

What subject(s) are you strongest in? \_\_\_\_\_

What subject(s) are you weakest in? \_\_\_\_\_

**Activities and Interests**

What do you do for fun? \_\_\_\_\_

What kind of music do you listen to? \_\_\_\_\_

Any current favorite artist, tape, or song? \_\_\_\_\_

**Friends**

How much time do you spend with friends?     a lot of time             some time             not much time

Do you have a "best" friend?  Yes     No

If so, how long have you known him/her? \_\_\_\_\_

Can you talk to this person about serious problems in your life? ( ) Yes ( ) No

Do you have a boyfriend/girlfriend? ( ) Yes ( ) No

If so, how long have you been dating? \_\_\_\_\_

Do people at school tend to label your group of friends (e.g. skaters, metal heads, preps, etc.)?

( ) Yes ( ) No

If so, what label would you usually be given? \_\_\_\_\_

**Health**

How would you rate your overall health? ( ) good ( ) fair ( ) poor

Check all that apply to you:

- ( ) I have headaches once a week or more.
- ( ) I have gained 10 lbs. or more within the past 2 months.
- ( ) I have lost 10 lbs. or more within the past 2 months.
- ( ) I have difficulty falling asleep.
- ( ) I wake up frequently during the night
- ( ) I wake up very early and can't get back to sleep.
- ( ) I feel tired much of the time
- ( ) I have a hard time concentrating.
- ( ) My memory is not as good as it used to be.

Check all the feelings that you often have:

- |                         |                    |              |
|-------------------------|--------------------|--------------|
| ___happy                | ___sad             | ___angry     |
| ___irritable/"touchy"   | ___anxious/nervous | ___bored     |
| ___confused             | ___confident       | ___shy       |
| ___"hyped up"/energetic | ___guilty          | ___depressed |
| ___worried              | ___lonely          | ___worthless |

**Drug and Alcohol Use**

	never	tried	rarely	monthly	weekly	daily
How often do you drink?	( )	( )	( )	( )	( )	( )
Smoke cigarettes?	( )	( )	( )	( )	( )	( )
Smoke marijuana?	( )	( )	( )	( )	( )	( )
Use other drugs?	( )	( )	( )	( )	( )	( )

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

**Family**

Fill in all that apply to you:

How well do you get along with your:

mother \_\_\_\_\_

father \_\_\_\_\_

stepmother \_\_\_\_\_

stepfather \_\_\_\_\_

brother(s) \_\_\_\_\_

sister(s) \_\_\_\_\_

stepbrother(s) \_\_\_\_\_

stepsister(s) \_\_\_\_\_

Please list any major changes in your life over the past five (5) years: \_\_\_\_\_

\_\_\_\_\_

If there anything else you want me to know about you? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*Thanks for filling this out. Your information will help me a lot in helping you and/or your family.*