Kenneth England Therapy

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ADOLESCENT INFORMATION FORM

Name of Patient _____ Date _____

Date of Birth _____ Age _____ Gender: Male_____ Female_____

Parent or Guardian _____

Address _____City _____State _____Zip_____

Home Phone _____ Cell Phone _____ Ok to leave message? Yes ___ No ___

E-mail Address _____ Ok to contact by e-mail? Yes ___ No ___

Emergency Contact _____ Phone Number _____

Who Referred _____ Can we thank them? Yes ___ No ___

Responsible Party/Subscriber_____ Subscriber Date of Birth _____

Employer_____

Insurance Carrier _____ Subscriber No. _____ Group No._____

Co-Pay Amount _____ Deductible Amount _____ Is Your Deductible Met? Yes ____ No ____

If you have arranged in advance with your therapist to bill insurance please sign the release below:

I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the supplier for services rendered.

Signed: _____ **Date:** _____

Note: If Parents are Divorced - Please Present Copy of Court Ordered Legal Custody Agreement

Reasons for seeking therapy

_____

_____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address:_____Physician's Phone:_____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES / NO

Please sign here for either answer:_____

Date of last medical evaluation:_____ Date of next appointment:_____

Current medications being taken:

1)_____ Dosage/Freq _____ Start Date_____Purpose_____

2)_____ Dosage/Freq _____ Start Date_____Purpose_____

3)_____ Dosage/Freq _____ Start Date_____Purpose_____

4)_____ Dosage/Freq _____ Start Date_____Purpose_____

Prescribed by:_____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle One) YES / NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____

Describe any important medical history, chronic ailments, or other health problems you experience:_____

_____

_____

_____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments:_____

_____

_____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:_____

_____

_____

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Circle One) YES / NO

If yes, please explain:_____

What was the last year of school you completed? _____ What school are you currently attending? _____

Who is in your current support network? (friends, relatives, other adults):_____

_____

Please check all information, which applies to your biological parents:

MOTHER	FATHER
____ living	____ living
____ deceased	____ deceased
____ married	____ married
____ divorced	____ divorced
____ remarried ____# of times	____ remarried ____# of times

With whom do you live? Mother____ Father____ Stepmother____ Stepfather____ Guardian ____ Grandparent____

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom?

_____

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Describe your relationship with your mother:

Currently:_____

_____

In the past: _____

_____

Describe your relationship with your father:

Currently:_____

_____

In the past: _____

_____

Describe your relationship with your stepmother:_____

_____

Describe your relationship with your stepfather:_____

_____

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse:_____

_____

Sexual/physical/emotional abuse:_____

_____

MENTAL STATUS

Please check any of the following that describe how you believe you feel:

____ sad ____ anxious ____ depressed ____ frightened ____ guilty ____ angry ____ ashamed ____ aggressive ____ resentful
____ worthless ___ tearful ____ irritable ____ confused ____ extreme ups/downs ____ jealous ____ hopeless ____ helpless

Describe any other feelings you have had:_____

_____

Please check any of the following risk-taking behaviors you have engaged in:

___street racing ___gang involvement ___skip school ___dropped out ___dangerous dieting ___cutting ___stealing
___unprotected sex ___running away ___bullying others ___fire starting ___hurt animals ___restrict or restricted food intake
___over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

____beer ____wine ____hard liquor ____pot ____cocaine ____heroin ____Ecstasy ____speed ___over the counter drugs
____prescription drugs ____ice ____Triple C's ____dones ____quad bars ____Other:_____

Have you had any change in sleeping habits? (Circle One) YES / NO

Describe:_____

_____

Have you had any change in eating habits? (Circle One) YES / NO

Describe:_____

_____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES / NO

If so, please give a brief description with dates:_____

_____

Have you ever **considered suicide** in the **past**? (Circle One) YES / NO

If so, please give a brief description with dates:_____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES / NO

If so, please give a brief description with dates:_____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES / NO

If yes, please explain:_____

Have you ever **considered homicide** in the **past**? (Circle One) YES / NO

If yes, please explain:_____

LEVEL OF FUNCTIONING

List any current problems you are having in daily psychological, social or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members):_____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES / NO

Describe:_____

How much time do you spend online or gaming? _____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

Notification and Acknowledgement of Notice of Privacy Practices Regarding Protected Health Information

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a patient you have a right to a copy of that Notice.

We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from the same location[s] noted on our Privacy Practices Handout.

Please acknowledge your receipt of this notification by signing below.

Thank you

Responsible Party Signature: _____ Date: _____