Susan Dellutri, LLC

Adolescent Health and History Questionnaire

To be filled out by legal guardian

Client's Name_____ DOB_____ Gender_____ Date_____
Form Completed by_____ Relationship to Client_____

Household Members *Primary* Residence				**Household Members *Secondary* Residence**		
Name	Age	Relationship to Client		Name	Age	Relationship to Client

REASON FOR SEEKING COUNSELING FOR YOUR ADOLESCENT

Briefly describe the problem for which your adolescent is seeking to have counseling for?_____

_____

_____

What would you like to see happen as a result of counseling?_____

_____

What is most concerning right now?_____

_____

COUNSELING/MEDICAL HISTORY

Has your adolescent previously seen a counselor? (Y/N)_____
If yes, counselor's name_____ Approximate dates_____
For what reason did your adolescent go to counseling?_____
What did **you** find **most helpful** in or as a result of therapy?_____

_____

What did **you** find **least helpful** in or as a result of therapy?_____

_____

What was their previous mental health diagnosis?_____
Has your adolescent taken medication for a mental health concern? (Y/N)_____

Name of Medication	Dates Taken	Was it Helpful?	List side effects	Prescriber's Name

Does your adolescent have a primary care doctor? (Y/N)_____
If yes, doctor's name_____
Are you aware of any complications with the pregnancy or delivery of the client? (Y/N)_____
If yes, please describe_____
Did the client have health problems at birth? (Y/N)_____If yes, please describe_____
_____
Did the client experience any developmental delays (e.g. toilet training, walking, talking)? (Y/N/Unsure)_____
If yes, please describe_____
Did the client have any unusual behaviors or problems prior to age 3? (Y/N/Unsure)_____
If yes, please describe_____
Does the client have other medical concerns or previous hospitalizations? (Y/N)_____
If yes please describe_____
_____
Has the client experienced emotional, physical or sexual abuse? (Y/N/Unsure)_____
If yes, please describe_____
_____

CHEMICAL USE
Do you have any concern with your adolescent using alcohol or drugs? (Y/N)_____
If so, please explain your concern_____
_____

INTERNET/ELECTRONIC COMMUNICATIONS USAGE
Do you have any concerns with your adolescent using the internet or electronic communication? (Y/N)_____
If yes, please explain your concern_____

EDUCATIONAL HISTORY
What school does your child attend?_____ Grade_____
Did your adolescent ever repeat a grade? (Y/N)_____ Dis your adolescent ever skip a grade? (Y/N)_____
If so, what grade & reason?_____
What kind if grades does the client get?_____
Are you satisfied with your adolescent's grades? (Y/N) _____
Is your adolescent satisfied with their grades? (Y/N)_____

Please check any of the following services that your child has ever received or has difficulties with:

	Special Ed/Resources Services		IEP (Individualized Educational Plan)
	Occupational Therapy		504 Plan Reason:_____
	Self-contained classroom		Spelling difficulties
	Peer relationship issues		Reading difficulties
	Physical Therapy		Math difficulties
	Speech/Language Therapy		All subject difficulties
	Social Work/Counseling at school		Receives after school help
	Has a tutor or in class aide		Gifted/Accelerated classes

FAMILY HISTORY

Is the adolescent adopted? (Y/N)_____ If so, at what age?_____ If so, is he/she aware? (Y/N)_____
Parent's marital status ____Single ___Married ___Divorced ___Cohabitating ___Separated ___Widowed ____Divorce in process ___Other
If divorced or separated, how old was the client at that time?_____

(Please answer the following as best as you can, we understand that you may not be able to answer some of the questions pertaining to the other parent)

Parent #1 Name_____ Birth Date_____ Age_____
Ethnic Origin_____ Religious/Spiritual Preference_____
Total years of education completed_____ Occupation_____
Place of Employment_____
Military experience? (Y/N)_____ Combat experience? (Y/N)_____
Did you experience childhood abuse in your home (physical, verbal, emotional, or sexual)? (Y/N)_____
Please describe as much as you feel comfortable_____
_____
Have you experienced abuse in adult life? (Y/N)_____ Please describe as much as you feel comfortable_____
_____

Parent #2 Name_____ Birth Date_____ Age_____
Ethnic Origin_____ Religious/Spiritual Preference_____
Total years of education completed_____ Occupation_____
Place of Employment_____
Military experience? (Y/N)_____ Combat experience? (Y/N)_____
Did you experience childhood abuse in your home (physical, verbal, emotional, or sexual)? (Y/N)_____
Please describe as much as you feel comfortable_____
_____
Have you experienced abuse in adult life? (Y/N)_____ Please describe as much as you feel comfortable_____
_____

If divorced, how much time does the client spend with each parent? Parent #1_____% Parent #2_____%

FAMILY CONCERNS (*Please check any family concerns that your family is currently experiencing. If divorced, please indicate parent house #1 or parent house #2)*

	Fighting		Disagreeing about relatives
	Feeling distant		Disagreeing about friends
	Loss of fun		Alcohol use
	Lack of honesty		Drug use
	Physical fights		Infidelity
	Education problems		Divorce/separation
	Financial problems		Issues regarding remarriage
	Death of a family member		Birth of a sibling
	Abuse/neglect		Legal issues
	Inadequate housing/feeling unsafe		Inadequate health insurance
	Job change or job dissatisfaction		Trauma
	Medical concerns		Other

YOUR ADOLESCENT'S STRENGTHS

What activities do you feel your adolescent is successful when they try?_____

_____

_____

What personal qualities would you say your adolescent has?_____

_____

_____

Who or what are some of the influential and supportive people, activities, or beliefs in your adolescents life? Please describe:_____

_____

INDIVIDUAL CONCERNS *(Please check any symptoms or concerns that you see in your adolescent)*

SYMPTOM	NONE	MILD	MOD	BAD		SYMPTOM	NONE	MILD	MOD	BAD
Sadness						Appetite change				
Crying						Social Isolation				
Trouble Sleeping						Paranoid Thoughts				
Weight Changes Unplanned						Poor Concentrartion				
Problems at home						Indecisiveness				
Hyperactivity						Low Energy				
Binging/Purging						Excessive Worry				
Loneliness						Low Self Worth				
Unresolved Guilt						Anger Issues				
Irritability						Spiritual Concerns				
Nausea/IBS						Hallucinations				
Social Anxiety						Racing Thoughts				
Self Mutalation						Restlessness				
Cutting						Drug Use				
Impulsivity						Alcohol Use				
Nightmares						Easily Distracted				
Hopelessness						Trauma Flashback				
Elevated Mood						Panic Attacks				
Obsessive Thoughts						Past Suicide Attempts				
Mood Swings						Feeling Anxious				
Disorganized						Feeling Panicky				
Anorexia						Suicidal Thoughts				
Grief						Phobias				
Headaches						Other				

LEGAL ISSUES

Please list any legal issues that are affecting you or your family, at present, or have had a significant effect upon you or your adolescent in the past._____

_____

Is there anything else you would like to share?_____

_____

I have access to a copy of "Minor's Privacy Rights Related to Assess, Inspection & Copying of Protected Health Information" on Susan Dellutri. LLC website or a paper copy upon request.

Signature_____ Date_____