Gettysburg Counseling, LLC
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Gettysburg, PA 17325
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Adolescent Information Form

*** **Parent or Guardian – *please have adolescent complete this form independently.***

Note: Unless there is a serious risk of injury to you or someone else, the information on this form is confidential. It will not be discussed with your parents without your consent.

Your name:

Today's date: Your age:

Your address: Phone #:

Health
What physical or medical problems do you have now, or have you had in the past?

What concerns do you have about your body or physical appearance?

Family
Birth parents' names:

Address: Phone #:

Present parents'/guardians' names: and

Address: Phone #:

How would you describe your parents' relationship?

What kinds of problems are you having with:

- Parents/stepparents/guardians?

- Parents' live-in friends or boyfriends/girlfriends?

- Brothers or sisters (or stepbrothers or stepsisters)?

School
Which school do you go to? Grade level/year:

How are your grades?

Problems in school?

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Work
Do you work? If so, where?

Problems there?

Friends
Who are your close friends (first names and ages)?

Do you have a serious one-on-one relationship now?

Do you party? If so, when and where? *(per PA treatment laws, this information cannot be disclosed to parents without your permission if you are at least 14 years old)*

	Age at first use	Date of most recent use	Current amount per sitting
Alcohol			
Marijuana			
Cocaine			
Crack Cocaine			
Ecstasy			
Heroine			
Barbiturates			
Pain killers			
Crystal Meth			
Prescription or "over the counter"			
Other:			

Describe family drug and alcohol use/abuse history:

Anyone ever express concern about your alcohol or drug use? Yes No

History of use while driving? Yes No
If yes to either question, please describe:

Previous counseling
1. With whom? When?

For what?

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Concerns
Would you like information or answers on: ❑ Sex ❑ Alcohol ❑ Drugs (If so, which?)
❑ Birth control ❑ Relationships ❑ Other:

Is religion important to you and/or your family? If so, in what ways?

What worries or upsets you?

Have you ever thought of harming yourself?

Do you ever cut/burn/harm youself for relief?

What angers you?

What makes you happy?

Why do you think you are here? Please tell me in your own words.

What would you like to see happen or change because of this counseling?

What would you like me to let your parents know?

What else is important for me to know?

What would you like me to ask you about?

_____ Date: _____
Signature of Adolescent

_____ Date: _____
Rebecca Uppercue, LCSW
Licensed Clinical Social Worker

Adapted from a form devised by Nora Fleming Young, PhD,of Sedro-Woolley, WA and *The Paper Office*. Copyright 2003 by Edward L. Zuckerman.