21000 Rogers Drive, Suite 100
Rogers, MN 55374
763/424-1888

PERSONAL HISTORY FORM-MINOR

Client name: ____Age: _____ D.O.B. __________ Gender: M F

Parents' names: ____

If parents are not married, who has legal custody? ___ Mother ___Father ___Other: _________________________________

If parents are not married, explain physical custody arrangements: ____

____
_

Primary reason(s) for seeking services:

____ Depression ____ Anxiety ____ Alcohol/drugs ____ Anger management
____ Coping ____ Fear/phobias ____ Behavior problems ____ Family issues/conflict
Other: ____

Please circle behaviors and symptoms that are problematic:

Aggression	Worrying	Hallucinations	Attention Deficit
Anxiety	Heart Palpitations	People avoidant	Trouble concentrating
Depression	Recurring thoughts	Disorientation	Sexual problems
Alcohol problems	Irritability	Cyber addiction	Antisocial behavior
Fatigue	Impulsivity	Speech problems	Sleep problems
Panic attacks	Distractibility	Gambling	Fears/phobias
Anger	Chest pain	Sick often	Self injury/behavior
Hopelessness	Loneliness	Drug problems	Memory problems
Suicidal thoughts	mood swings	Eating issues	withdrawing

Does the minor report felling suicidal at this time? Yes or No
Does the minor report having a plan for suicide? Yes or No
Please include any additional information that would assist us in understanding your concerns and problems?
____
____
____
___

Has the minor recently experienced any that follow?

Recent death or birth in the family	Accident, fire, disaster	Separation or divorce
Job loss or change	Arrest or DUI	Major Financial problems
Change in living arrangements	Physical/emotional abuse	Sexual abuse or assault
Thoughts/acts of violence to others	Thoughts/acts of hurting self	Custody issues
Pregnancy, miscarriage, abortion	Diagnosis of major illness	Significant relationship discord

Developmental History

Has there been a history of child abuse? Yes or No   If yes, which type: ___ Sexual   ___ Physical   ___Verbal
Other childhood issues: ___Neglect   _____Exposure to trauma   _____Inadequate nutrition
Are there any special, unusual, or traumatic circumstances that affected your upbringing? Yes or No
Please explain ____

Social Relationships

Circle how the minor generally gets along with other people:

Affectionate	Aggressive	Avoidant	fight/argue often	Follower
Friendly	Leader	Outgoing	Shy/withdrawn	Submissive

What is the minor's sexual orientation? ____

Is the minor sexually active? Yes or No

Spiritual/Religious

Are you connected with a spiritual or religious group? Please explain________________________________
Were you raised within a spiritual or religious group? Yes or No
Would you like your spiritual beliefs incorporated into the counseling? Yes or No

Legal

Involved in any active legal cases (traffic, civil, criminal)? Yes or No
If yes, please describe charges ____
Currently on probation or parole? Yes or No
Accusations of any sexual crimes? Yes or No

Education, Employment, Military (circle)

Education:	Currently enrolled in school	High school grad/GED	Vocational school
	Some College	College Graduate	Masters or Doctorate

Any learning disabilities: Yes or No If yes, please explain _______________________________________

Employment: Current employer ____

Fulltime	Part time	Temp	Laid-off	Disabled	Retired	Social Security
Job satisfaction:		poor	good	fair	great	

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, crafts, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling sports, etc.)
____
____
__

Medical/Physical Health

Primary care Doctor ___________________________________   phone ______________________________
List any current health conditions/recent health changes: ____
Currently using any prescribed medications: ____

Please circle if there have been any changes in the following:

Sleep patterns | Eating patterns | Behavior | Energy level | Physical activity level

General disposition | Weight | Nervousness/tension

Others: ____

Chemical use History

	Method of use and amount	Frequency of use	Age of first use	Age of last use	Used in last 48 hrs	Used in last 30days
					yes	yes
Alcohol	______	______	______	______	yes	yes
Cocaine/Crack	______	______	______	______	yes	yes
Meth	______	______	______	______	yes	yes
Marijuana	______	______	______	______	yes	yes
Valium/Librium	______	______	______	______	yes	yes
Heroin/Opiates	______	______	______	______	yes	yes
PCP/LSD/Mescaline	______	______	______	______	yes	yes
Inhalants	______	______	______	______	yes	yes
Caffeine	______	______	______	______	yes	yes
Nicotine	______	______	______	______	yes	yes
Pain killers	______	______	______	______	yes	yes

Drug of choice: ____

How does use affect your life? ____

Has anyone expressed concern about use? Yes or No

Is minor concerned about use? Yes or No

Are there presently or past history of a family member having problems with drugs or alcohol? Yes or No

Consequences experienced because of use? Legal, relational, physical, mental, job, financial

Please explain: ____

____

Counseling Prior treatment History

Information about client (past and present):

	Yes	No	When	Where
Counseling/Psychiatric Care	___	___	________	________
Suicidal thoughts/attempts	___	___	________	________
Drug/alcohol treatment	___	___	________	________
Hospitalizations	___	___	________	________

Is there a family history of mental illness or substance abuse problems? ______________________

Please list treatment goals wished to accomplish.

____

____

____

____

Thank you for your time completing the questionnaire.

ADOLESCENT BEHAVIOR CHECKLIST

Name: ____________________________________ DOB: _____________ Date: ______________

	ATTENTION		**CONDUCT**
	Makes careless mistakes		Stolen items
	Attention span is poor or limited		Forces sexual activity
	Doesn't listen to simple instruction		Deliberately sets fires
	Avoids tasks requiring concentration		Lies or cons
	Doesn't finish tasks completely		Broken into property
	Problems organizing self		Bullies, threatens others
	Loses needed items often		Starts fights
	Easily distracted		Used a weapon
	Forgetful		Physically cruel to people/animals
	Fidgets, squirms		Forcibly stolen from victim
	Leaves set when required to sit		**ANXIETY/WORRY**
	On-the-go, seems driven		Intense fears or phobias
	Runs, climbs or excessively restless		Worries something terrible will happen to self/adults
	Talks excessively		Refuses/reluctant to go somewhere because of fear
	Interrupts others conversation or activity		Frequent fear to go to sleep without someone
	Problems waiting for a turn		Avoids being alone, clingy
	Bizarre behaviors		Nightmares about separation
	MOOD		Physical complaints, about the time of separation
	No symptoms for more than two months during past year		Worries about parent(s) leaving
	Weight changes, appetite changes		Obsessive or compulsive behavior or rigid rituals
	Energy level changes		Extreme fear of new places or situations
	Sleep disturbances		**OPPOSITIONAL BEHAVIORS**
	Concentration problems		Touchy, easily annoyed
	Crying spells		Argues
	Loss of interest, pleasure in once enjoyable activities		Defiant
	Hopeless feelings		Tantrums
	Guilty feelings		Bothers others deliberately
	Isolates self		Spiteful/Mean
	Low self-esteem		Blames others for own mistakes
	Gives things away		**OTHERS:**
	Wishes to be dead/talks of death		
	Injures self		
	Thinks about death/violence often		
	Rage outbursts		
	Thinks she/he is smartest, best person in the world		

MY STRENGTHS:

In school settings: ____

____

In social settings: ____

____

Special Interests/Hobbies: ____