**Adolescent Confidential Information Assessment**

Name:_____
Date of Birth:_____Phone Number:_____
Address:_____
Emergency Contact Name: _____
Phone Number:_____Relationship:_____
What brings you to counseling:_____
_____
_____
Do you have any thoughts of harming yourself?_____
Do you have any thoughts of harming someone else?_____
Do you experience explosive anger?_____
Do you have any previous experiences with counseling?_____
Do you have any experiences of abuse or neglect currently or in the past?
(If yes please explain)
_____
_____
_____
Has any one in your family struggled with mental health or substance abuse
issues that you know about? (Examples: anxiety, depression, alcoholism, suicide)
_____
_____
_____
Have you ever been suspended, expelled, or involved in any way with bullying?_____
_____
Are you currently struggling with any legal issues? _____
Do you have any current or historical medical issues? If so please
list:_____
_____
_____
Are you able to complete all activities of daily living and self care? If no, please explain.
_____
_____
List of current medications including supplements:
_____
_____
Do you currently use tobacco or caffeine? If yes how much and how
often?._____
_____
Have you ever consumed alcoholic beverages? If yes how much and how often?
_____
Have you ever used drugs (Examples: marijuana, cocaine, LSD, heroin, ecstasy)? If so
how much and how often?_____
_____

_____ _____
Signature Date