



Mahy Counseling and Consulting
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INSTRUCTIONS: PLEASE COMPLETELY FILL OUT BOTH SIDES.

Date: _____ Form filled out by: _____
Client Name: _____ Date of Birth: _____
Age: _____ Gender: Female Male
Referred By: _____ Primary Care Doctor: _____

Address: _____ City/State/Zip: _____
Home Phone #: _____ Cell #: _____ Work Phone #: _____
OK to leave message? YES NO YES NO YES NO

Mothers Name: _____ **Date of Birth:** _____ **SSI#:** _____
Address (if different than above): _____ **City/State/Zip:** _____
Phone # (if different than above): _____ **Cell:** _____ **Okay To Leave Messages At These Numbers:** Yes No
Mothers Employer: _____ **Address:** _____ **Phone#:** _____
Fathers Name: _____ **Date of Birth:** _____ **SSI #:** _____
Address (if different that above): _____ **City/State/Zip:** _____
Phone # (if different than above): _____ **Cell:** _____ **Okay To Leave Messages At These Numbers:** Yes No
Fathers Employer: _____ **Address:** _____ **Phone#:** _____

Person Responsible for Payment: _____

Childhood Health: (check all that apply)

Visual Problems
Hearing Problems
Problems with Coordination
Physical, Sexual or Emotional Abuse
Weight Loss/Gain
Speech Problems

Ear Infections
Headaches
Nausea/Vomiting
Lead Poisoning
Seizures
Soiling/Bedwetting
Head Injury

Broken Bones
Asthma
Stomach Aches
Allergies to: _____

Any Chronic or Serious Health Problems: _____

MEDICAL HISTORY

Describe Current Physical Health: Good Fair Poor

List All Medications Teen Is Taking. Include Non-Prescription Drugs And Health Supplements.

Drug Name	Purpose	Dosage	# Per Day
1.			
2.			
3.			

Prescribed By: _____

Do You Have Any Allergies To Medication? Yes No If yes, which ones? _____

Describe Any Hospitalization, Surgeries or Accidents

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

Date: _____ Age: _____ Reason: _____

SUBSTANCE USE

Check Past or Current Substance Use:							
	Past Use	Current Use	How Often		Past Use	Current Use	How Often
Hard Liquor	<input type="checkbox"/>	<input type="checkbox"/>		Tranquilizers/Sleeping Pills	<input type="checkbox"/>	<input type="checkbox"/>	
Beer/Wine	<input type="checkbox"/>	<input type="checkbox"/>		Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>		Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	
Speed/Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>		Nicotine	<input type="checkbox"/>	<input type="checkbox"/>	
Heroin/Painkillers	<input type="checkbox"/>	<input type="checkbox"/>		Coffee	<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinogens/Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>		Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	
PCP	<input type="checkbox"/>	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>	

Consequences of Substance Abuse: (check all that apply):

Hangovers
Seizures
Blackouts
Overdose
Withdrawal Symptoms
Medical Conditions

Changes
Loss of Control Amount Used
Sleep Disturbance
Assaults
Suicidal Impulse
Relationship Conflicts

Binges
Interference with School
Job Loss
Arrests

Check Any of the Conditions Your Teen Has Had and the Date of Onset:

Condition	Date	Condition	Date	Condition	Date
ADD/ADHD		Cancer		Learning Disability	
AIDS/HIV		Diabetic		Low Blood Pressure	
Allergies		Epilepsy		High Blood Pressure	
Anemia		Head Trauma		Obesity	
Arthritis		Heart Disease		Migraines	
Asthma		Hyperactivity		Stomach Ulcers	
Autism		Hypoglycemia		Thyroid Disease	
Asperger's		Panic Attacks		Skin Problems	
Depression		Anxiety Attacks		Obsessive/Compulsive	
Behavior Problems		Other:			

Check Any of The Following Your Teen Has Had In The Past Three Months:

- | | | |
|---------------------|--------------------------|--------------------------|
| Vision Problems | Weakness in Arms or Legs | Chronic Pain |
| Stomach Aches | Constipation | Fainting |
| Memory Loss | Loss of Consciousness | Nausea or Vomiting |
| Dizziness | Chest Pains or Tightness | Unusual Bleeding |
| Shortness of Breath | Hearing Loss | Menstrual Irregularities |
| Back Pain | Convulsion/Seizures | Headaches |
| Head Injury | Diarrhea | Abnormal Growth or Lump |

Psychiatric History:

Prior **Outpatient** Therapy? Yes No Provider Name: _____ Was It Beneficial?: Yes No

Prior **Inpatient** Therapy? Yes No Facility Name: _____ Was It Beneficial?: Yes No

Is There a History of Any of the following In the Family:

	PARENT	SIBLING		PARENT	SIBLING		PARENT	SIBLING
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease/Dementia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive/Compulsive	<input type="checkbox"/>	<input type="checkbox"/>
Anger Problems	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Suicide/Homicide	<input type="checkbox"/>	<input type="checkbox"/>
Behavior Problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asperger's	<input type="checkbox"/>	<input type="checkbox"/>
Violent or Abusive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	Panic Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Other:		

Academic Functioning (for your teen): (check all that apply)

- | | | |
|------------------------------|----------------------------|--------------------|
| Learning Problems | Difficulties with Homework | Attention Problems |
| Difficulties with Schoolwork | Authority Conflicts | Underachieving |

Current or Highest Education Level: _____ School: _____

Cultural/Spiritual (e.g., ethnicity, religion): _____

Family of Origin

Parents Current Marital Status:

	Present Entire Childhood	Present Part of Childhood	Not Present At All	Current Age
Mother				
Father				
Stepmother				
Stepfather				
Brother(s)				
Sister(s)				
Other (specify)				
Stepbrother(s)				
Stepsister (s)				

Married to Each Other for _____ Years

Separated for _____ Years

Divorced for _____ Years

Mother Remarried _____ Times

Father Remarried _____ Times

Mother Involved with Someone

Father Involved with Someone

Mother Deceased For _____ Years

Father Deceased For _____ Years

List Any other person Living In Teen's Home

Name:	Age:	Relationship to Teen:

LIST OF TEENS BEHAVIORS: Please use the following scale to rate your child on each behavior. Indicate how often your child displays that behavior by circling the number which best describes the frequency of each behavior.

1 Never
 2 Rarely
 3 Occasionally
 4 Frequently
 5 Very Frequently

1	2	3	4	5	Has trouble Sleeping
1	2	3	4	5	Has Poor Appetite
1	2	3	4	5	Seems Sad or Unhappy
1	2	3	4	5	Talks About Feeling Stupid or Worthless
1	2	3	4	5	Loses Interest in Having Fun
1	2	3	4	5	Seems Irritable
1	2	3	4	5	Moody
1	2	3	4	5	Plays Alone
1	2	3	4	5	Cries Easily
1	2	3	4	5	Seems Tired

1	2	3	4	5	Refuses to Follow or do Chores
1	2	3	4	5	Loses Temper
1	2	3	4	5	Argues with Parents or Teachers
1	2	3	4	5	Blames Others for Their Mistakes
1	2	3	4	5	Swears
1	2	3	4	5	Deliberately Does Things to Annoy Other People
1	2	3	4	5	Is Angry or Resentful
1	2	3	4	5	Carries a grudge, Seems to have "A Chip on Their Shoulder"
1	2	3	4	5	Touchy, Easily Annoyed By Others

1	2	3	4	5	Complains About Physical Problems: Like Headaches or Stomachaches
1	2	3	4	5	Worries
1	2	3	4	5	Lacks Confidence in Their Abilities
1	2	3	4	5	Needs Lots of Reassurance
1	2	3	4	5	Needs to be Perfect
1	2	3	4	5	Seems Fearful and Anxious
1	2	3	4	5	Seems Shy or Timid
1	2	3	4	5	Easily Embarrassed
1	2	3	4	5	Sensitive to Criticism
1	2	3	4	5	Bites Fingernails

1	2	3	4	5	Steals
1	2	3	4	5	Runs Away Overnight
1	2	3	4	5	Lies
1	2	3	4	5	Skips School
1	2	3	4	5	Is Cruel to Animals
1	2	3	4	5	Destroys Property
1	2	3	4	5	Gets Into Fights
1	2	3	4	5	Has Been Physically Cruel to Other People
1	2	3	4	5	Doesn't Seem Sorry For Hurting Others
1	2	3	4	5	Sets Fires
1	2	3	4	5	Has Broken Into Someone Else's House or Car

1	2	3	4	5	Always on The Go
1	2	3	4	5	Can't Sit Still
1	2	3	4	5	Doesn't Seem To Listen
1	2	3	4	5	Often Fails to Finish Things
1	2	3	4	5	Has Poor Concentration and Attention When Comes to Schoolwork
1	2	3	4	5	Often Fidgets with Hand/Feet or Squirms in Seat
1	2	3	4	5	Easily Distracted
1	2	3	4	5	Has a Hard Time Playing Quietly
1	2	3	4	5	Talks Excessively
1	2	3	4	5	Often Interrupts or "Butts In" to Others' Games
1	2	3	4	5	Seems Disorganized, Loses Things They Need For School
1	2	3	4	5	Takes Risks Without Considering The Danger Involved (e.g. Running into the Street Without Looking)
1	2	3	4	5	Blurts Out Answers to Questions Before They Have Been Completed

1	2	3	4	5	Compulsive Behavior
1	2	3	4	5	Alcohol or Drug Use
1	2	3	4	5	Lack of Attachment
1	2	3	4	5	Dependent of Separation Problems
1	2	3	4	5	Self-Injury Acts
1	2	3	4	5	Self-Injury Threats
1	2	3	4	5	Indecisive
1	2	3	4	5	Immature
1	2	3	4	5	Odd Behavior
1	2	3	4	5	Upset with Physical Appearance
1	2	3	4	5	Sexual Behavior
1	2	3	4	5	Distrustful
1	2	3	4	5	Concerns Regarding Peer Influence
1	2	3	4	5	Teased or Bullied
1	2	3	4	5	Watches Television
1	2	3	4	5	Plays Video Games
1	2	3	4	5	Internet Use

Form Completed By: _____ **Date:** _____

Other information on Teen's behavior:

Has your teen experienced any serious upsets? YES NO If yes, what kind: _____

Has your teen suffered any significant losses? YES NO If yes, please explain: _____

Does your teen have any particular fears? YES NO Comments? _____

Any problems with sleeping? YES NO Comments? _____

Any problems with discipline? YES NO If yes, please describe: _____

How active is your teen? _____

List your teen's strengths: _____

Please add any information you feel would be helpful: _____

TREATMENT GOALS:

Please List Issues To Discuss In Therapy Which Are A Primary Concern And Specific Goals You Wish To Accomplish:
