Priscilla J. Colvin King, LLC
Adolescent Information

Please provide the following information regarding your child/adolescent.

Please Print **Date ____________________**

Name ____

Address ____

City ______________________________State _____________Zip Code ____________

Sex: Male ______Female _____Date of Birth ______Age _________________________

Parent/Guardian Name ____

Address (if different from child) ____

City _______________________________State ____________Zip Code ____________

Father's Home Phone _______________Work ______________ Cell ______________

Mother's Home Phone _____________Work ________________Cell ______________

Person responsible for payment (if different) ____________________________________

Address____

City ______________________________State _________________Zip Code_________

Home Phone ____________________ Work _____________Cell __________________

How did you hear about me? ____

Religious affiliation ___________________Place of Worship _______________________

The information below will be helpful in understanding your child/adolescent. Please give me as much information as you think will be helpful. You may use the back of the sheets to give additional information.

Reasons for scheduling this appointment

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Medical History (List major illnesses, operations and injuries. Indicate age when occurred and describe how severe. List any previous psychological, psychiatric, or neurological evaluations. List any known allergies, vision, hearing, or speech problems.

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____

When did your adolescent last have a physical examination? ___________

List any prescription medications currently taking, dosage and reason for taking.

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____

Please list all people now living in the household

Name	Age	Relationship to Adolescent	Highest Grade of Ed	Occupation
____________	______	______________________	__________________	_____________
____________	______	______________________	__________________	_____________
____________	______	______________________	__________________	_____________
____________	______	______________________	__________________	_____________

Family history

(Include adoptions, re-marriages, previous marriages, and deaths in immediate family). Is the adolescent aware of this history?

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Were there any early patterns or experiences that you believe caused the current problems?

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Describe Your Adolescent's Current Functioning and Habits:

Appetite and eating habits ____

Sleep patterns: ____

Level of activity ____

Any problems sitting still or paying attention ____

Nervous habits such as hair pulling nail biting etc.) ____

____

Other habits or behavior that concern you (use of alcohol/drugs, smoking, cursing, shoplifting, obsessive worry, obsessive thoughts, etc.)

____

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____

Getting along with others

____

____

Pattern of interaction with opposite sex and any concerns about dating or sexual activity or identity

____

____

What your adolescent likes to do for fun, special interests, hobbies, etc.

____

____

Your method of discipline and how your adolescent reacts to discipline

____

____

____

Education History

Name of School ________________________________Grade ________________________________

School counselor ____

The school will not be contacted without a signed release of information.

List previous schools attended and dates or grades

____

____

____

Has your adolescent ever repeated a grade? Yes _No _If so, what grade? ________________________

If, so what was the reason? ____

What are his/her grades like now? ____

Describe any learning difficulties ____

____

Have there been any discipline or other behavior difficulties at school? Yes ____No

If so, please describe ____

____

Religious Background

Describe religious experiences, training, worship attendance, concept of God etc.

____

____

Problem Areas: Place a check next to each item, which identities an area of concern. Please place two checks by those items of most concern.

______ Anger

______ Depression

______ Eating difficulties

______Education

______Fearfulness

______Unhappy most of the time

______Religious/Spiritual concerns

______Problems with siblings

______Problems with parents

______Problems with relationships with opposite sex

______Problems with relationships with same sex

______Other (describe below)

______Worry

______Sleep problems

______Thoughts of hurting others

______Thoughts of suicide

______Trouble making decisions

______Use of alcohol

_____Sexual Concerns

_____Use of drugs

_____Use of tobacco

Information shared with me by your adolescent is confidential. Exceptions include a danger to self or others, or a report of abuse.

If your insurance company contacts us to obtain information necessary to process your claims (such as diagnosis, dates of service, etc.) do we have your permission to provide such information by phone, FAX, or by mail? Yes _________No ____

____ ________________________

Parent/Guardian Signature Date

____ ________________________

Witness (Office Staff Member) Date

Thank you for your time in completing this form.

Revised 1/09