Crain Counseling New Client Packet (Youth)

Client Name: _____
Last First MI (preferred name)

Please describe why you are seeking counseling

_____

_____

_____

Family History

Mother:

Name (Mother): _____

Give a description of your mother's personality and her attitude towards you _____

_____

Are you able to confide in your mother? ____ Yes ____ No

Do you feel loved, respected and accepted by your mother? ____ Yes ____ No

Is there anything notable, unusual or stressful about your relationship with your mother? ____Yes _____No

If Yes, please explain: _____

Father:

Name (Father): _____

Give a description of your father's personality and his attitude towards you: _____

_____

Are you able to confide in your father? ____ Yes ____ No

Do you feel loved, respected and accepted by your father? ____ Yes ____ No

Is there anything notable, unusual or stressful about your relationship with your father? ____Yes _____No

If Yes, please explain: _____

Give an impression of your home atmosphere: _____

_____

Medical History

On average how many hours do you sleep daily? _____

Do you have trouble falling asleep at night or waking in the middle of the night? Yes_____ No_____

If "Yes", how long has this been a problem? _____

Describe your appetite (during the past week): Poor _____ Average _____ Large _____

Comments on your eating habits/nutrition: _____

Do you use or have a problem with tobacco, alcohol, or other drugs? Yes_____ No_____

If Yes, describe: _____

Are you currently taking any medications, if so please list with dosage amount: _____

_____

Education

Current school: _____
Grade: _____ Teacher: _____ School Counselor: _____
Which subjects do you enjoy in school? _____
Which subjects do you dislike in school? _____
What grades do you usually receive in school? _____
Have there been any recent changes in your grades? ____ Yes _____ No
If Yes, describe: _____

Social History

___Yes ___No 1. Do you get along well with others your age?
___Yes ___No 2. Do you have trouble keeping friends?
___Yes ___No 3. Have you ever hurt anyone while fighting?
___Yes ___No 4. Have you had problems with being teased or bullied?
___Yes ___No 5. Do you prefer to be alone?
___Yes ___No 6. Do you have a close friend?
___Yes ___No 7. Are you as invited/included in activities (sleepovers, parties) as much as other teens?
___Yes ___No 8. Do you spend most of free time with older teenagers?
___Yes ___No 9. Are you quite conscious of your appearance or weight?
___Yes ___No 10. Do you find it easier to be friends with members of the opposite sex than those of the same sex?
___Yes ___No 11. Are you interested in the opposite sex?
___Yes ___No 12. Do you date? If yes, how old were you when you started? _____

Who are the important people in your life? _____
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, school activities, scouts, etc.)
_____
_____

How often does the family spend time together? How are family times usually spent? What are the family's favorite activities? _____
_____

Concerns and Goals

List your main difficulties in school:

1. _____
2. _____
3. _____

List your main difficulties at home:

1. _____
2. _____
3. _____

Please describe how you express anger: _____

Please describe how you express anxiety: _____

Please describe how you express happiness: _____

List three of your strengths:

1. _____
2. _____
3. _____

List three areas that need improvement:

1. _____
2. _____
3. _____

List your five main fears: _____

Have there been any other significant changes or events in your life? (family, moving, fire, etc.) __Yes ___ No

If Yes, describe: _____

Do you have a history or recent occurrence(s) of abuse? _____ Yes _____ No

If yes what kind(s)? _____Verbal/Emotional _____ Physical _____ Sexual

Please state when and describe: _____

_____

What family involvement would you like to see in counseling? _____

_____