BUILDING LIFELONG STRATEGIES FOR CHILDREN, TEENS & ADULTS

Dawn H. Nelson MA, NCC
Registered Psychotherapist
(970) 904-2558
dawn@centeredlifecounseling.com

Personal Information Form – Child & Adolescent

All information provided will remain confidential. If you are uncomfortable providing any information, please discuss with your therapist in person.

First Session Date:______________

Personal Information:

First Name:________________________ Last Name:________________________ Middle Initial:________

Nickname:_________________________ Date of Birth:_____________ Age:______ Sex: M F G L B T

Address:____

City:_____________________________ State:________________ Zip Code:________________________

Phone:___________________________________ Is it safe to leave a message? Y N

Email address:____

In case of emergency, please notify: ____

Religion:_________________________________

What is your birth order? ___________of ____________ children.

Who do you live with?____

What is your favorite childhood memory(s)?

____

____

____

Were there any traumatic events during your childhood?

____

____

____

Have you ever been the recipient of unwanted sexual contact? Y N

Referred by:_________________________________ May I thank this person for the referral? Y N

Work History:

Do you have a job? Y N Occupation:____

Employer: ________________________________ Hrs. / Wk. ________ How long at this job? __________

Dawn H. Nelson MA, NCC
Registered Psychotherapist

(970) 904-2558

dawn@centeredlifecounseling.com

BUILDING LIFELONG STRATEGIES FOR CHILDREN, TEENS & ADULTS

Who do you go to for support? Parent(s) Siblings Employer Church Friends Neighbor Other

What are your hobbies or leisure activities: ____

What do you do during your free time? ____

Medical History:

Are you currently under medical care? Y N (If yes, please indicate reason and provider)_____________
____

List any medications (prescribed, over the counter or herbal supplements you currently take):
____
____
____

Other significant medical history: ____
____
____
____

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist? Y N

Name:_________________________________ Date from _____________ to _________________

Primary reason for treatment ____

Do you think the time spent was beneficial/helpful? Y N

Have you ever attempted suicide? Y N Does anyone in your family have a history of suicide? Y N

Are you presently suicidal or homicidal? Y N

Have you ever inflicted burns or wounds upon yourself? Y N

Have you ever been the victim of abuse? Sexual Verbal Neglect Emotional Physical

Have you ever been violent toward others? Y N

Dawn H. Nelson MA, NCC
Registered Psychotherapist
(970) 904-2558
dawn@centeredlifecounseling.com

Substance Abuse History:

List your current usage (or usage in the past year). Include alcohol, tobacco, caffeine and non-prescription drug usage.

Substance	Amount	Frequency	Age of first use	Do you want to stop
________	________	________	________	Y N
________	________	________	________	Y N
________	________	________	________	Y N
________	________	________	________	Y N

Has there been an increase in the use of alcohol/substance within the past year? Y N

Do you, your friends or any family member see your current use as a problem? Y N

If yes, when would you say it became problematic? ______________________________

Are there any members of your family that have a history of substance abuse? ______________

____

Nutrition and Weight Management:

Have you noticed a change in your eating habits recently? Y N

Has your weight changed more than +/- 10 pounds over the past year? Y N

Do you find yourself eating due to stress, depression, anger, boredom? Y N

Have you taken any diet medication, laxatives or diuretics (water pills) to control your weight? Y N

Are you happy with your present weight? Y N

Are you happy with your present physical well-being? Y N

Additional:

In your own words, why are you seeking counseling at this time: ______________________

____

____

How long have these concerns been causing you distress? __________________________

What would you like to accomplish from your time in therapy? ________________________

____

____

CENTERED LIFE

BUILDING LIFELONG STRATEGIES FOR CHILDREN, TEENS & ADULTS

Dawn H. Nelson MA, NCC
Registered Psychotherapist
(970) 904-2558
dawn@centeredlifecounseling.com

What would you say are some of your personal strengths and current challenges?

Strengths	Challenges
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Checklist of Concerns:
Please circle any of the below that you've experienced during the past 6 weeks.

Anger	Sadness	Restlessness	Nightmares
Hurt feelings	Feeling out of control	Excessive Worry	Feeling Unloved
Guilt	Crying spells	Panic	Suicidal Thoughts
Fearful	Emotional Highs	Trouble Concentrating	Unnecessary Risks
Sleep Problems	Tired/Fatigue	Self-blame	Shyness
Violent Thoughts	Feeling Misunderstood	Irritable	Loneliness
Feeling Numb	Feeling helpless	Feeling shame	Feeling discontented
Self-Centered	Unambitious	Depressed	Bitterness
Hearing things	Repetitive thoughts	Confused	Relationship problems
Not smart enough	Not pretty enough	Thoughts of death	Nervousness
Hopelessness	Ashamed	Memory loss/gaps	Uncomfortable
Risk taking	Weight problems	Unwanted habits	Stuck
Unable to trust	Peer pressure	Career indecision	Am I normal
Problems at school	Problems at home	Problems at work	

Any other concerns that were not listed?____