

**PARENT OF ADOLESCENT HISTORY FORM** (to be completed by parent)

(Rev. 8-12-13)

The purpose of this questionnaire is to obtain a comprehensive view of your adolescent's background to save you and your counselor time. Please be complete and accurate. The information you provide is personal and will be kept confidential to the extent allowed by law. If you desire to not answer a question, simply write: "prefer not to answer." *Please print or write clearly.*

Your name & relationship to adolescent: \_\_\_\_\_

Adolescent's name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Gender: \_\_\_\_\_ Race: \_\_\_\_\_ Living situation (town/farm, house/apartment, etc.): \_\_\_\_\_

How did you choose Oasis Counseling? \_\_\_\_\_

Employer/school of parent(s): \_\_\_\_\_

Please list who lives in the adolescent's home:

Person & relationship	Age	Person & relationship	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PRESENTING PROBLEMS**

What concerns you most about this adolescent currently? \_\_\_\_\_

How have these issues affected this adolescent's ability to function (at home, at school, with friends): \_\_\_\_\_

What goals do you want counseling to achieve? \_\_\_\_\_

What specific changes in behavior will indicate to you these goals have been achieved? \_\_\_\_\_

In addition to counseling for this adolescent, do you also want help for yourself or your marriage? YES NO

If yes, please explain briefly: \_\_\_\_\_

Does this adolescent have any fears? YES NO If yes, what? \_\_\_\_\_

How do you handle them? \_\_\_\_\_

Does this adolescent have any angry outbursts or meltdowns? YES NO If yes, how often? \_\_\_\_\_

Are there any common causes? \_\_\_\_\_

What does he/she do? \_\_\_\_\_

How do you handle them? \_\_\_\_\_

Does this adolescent have crying spells? YES NO If yes, describe: \_\_\_\_\_

Does this adolescent have any problems with sleeping? YES NO If yes, describe: \_\_\_\_\_

To your knowledge, has this adolescent ever thought about or attempted suicide, cutting, running away, or other high risk behaviors?

YES NO If yes, please explain: \_\_\_\_\_

### ***SOCIAL***

Does this adolescent belong to any social or athletic groups? YES NO If yes, please specify: \_\_\_\_\_

What present hobbies, interests, or uses of free time does this adolescent have? \_\_\_\_\_

Do you believe this adolescent's social behavior is appropriate for his/her age? YES NO

Does this adolescent seek out others of the same age with whom to associate? YES NO

Is this adolescent able to appropriately "hold his/her own" in group situations? YES NO

Does this adolescent have a close friend? YES NO

Does this adolescent relate comfortably with members of his/her own gender? YES NO

Do you have a religious preference? YES NO If yes, what? \_\_\_\_\_

Does this family participate in a church, synagogue, mosque, or other religious group? YES NO

If yes, please specify: \_\_\_\_\_

How regular is this family's participation? \_\_\_\_\_

Does this adolescent also participate regularly? YES NO If so, in what ways? \_\_\_\_\_

How open are you to the counselor addressing spiritual issues with this adolescent, if relevant? \_\_\_\_\_

### ***FAMILY***

Marital status of parents (Circle one) Married Single Divorced Separated Widowed Live-in relationship

Has anyone other than parents and children lived in this home for an extended period of time? YES NO If yes, please describe who and when: \_\_\_\_\_

Which best characterizes the adolescent's overall current home environment?

\_\_\_\_\_ Unconditional love and acceptance, close relationships

\_\_\_\_\_ Quiet and peaceful, but relationships are distant

\_\_\_\_\_ Instability, periods of peace mixed with periods of fighting

\_\_\_\_\_ Family fighting is the norm

\_\_\_\_\_ Other: \_\_\_\_\_

How would you describe the happiness of the adolescent's parents' marriage?

\_\_\_\_\_ Very much in love, best of friends, happy

\_\_\_\_\_ Committed to one another, but not particularly close

\_\_\_\_\_ Unhappy, but trying to make the best of it

\_\_\_\_\_ Unhappy, avoid one another as much as possible, fights kept secret from children most of the time

\_\_\_\_\_ Unhappy, much fighting together, often in front of the children

\_\_\_\_\_ Separated or divorced, get along with each other

\_\_\_\_\_ Separated or divorced, openly antagonistic, ongoing conflicts

Circle what best describes your style of discipline.

<u>Mother:</u>	Strict with little compromise	Firm, but seek to give the adolescent a voice	Lenient	Few Limits
----------------	-------------------------------	---	---------	------------

Explain: \_\_\_\_\_

<u>Father:</u>	Strict with little compromise	Firm, but seek to give the adolescent a voice	Lenient	Few Limits
----------------	-------------------------------	---	---------	------------

Explain: \_\_\_\_\_

If this adolescent was/is not being brought up by her/his parents, who did/is doing the parenting? \_\_\_\_\_

How old was the adolescent when she/he was removed from the biological parent(s)? \_\_\_\_\_

Please briefly describe the circumstances. \_\_\_\_\_

How many times has the family moved since the adolescent was born? \_\_\_\_\_

What, if any, deaths have occurred among people the adolescent knows? \_\_\_\_\_ (or: N/A)

How has the family been impacted by the death(s)? \_\_\_\_\_

### ***MENTAL HEALTH HISTORY***

Has the adolescent had previous counseling? YES NO If yes, with whom? \_\_\_\_\_

For how long? \_\_\_\_\_ Approximately when? \_\_\_\_\_ How was the experience? \_\_\_\_\_

Has the adolescent ever been hospitalized for psychiatric reasons? YES NO If yes, where, when, why, and for how long? \_\_\_\_\_

To your knowledge, has the adolescent ever been suicidal? Please explain. \_\_\_\_\_

### ***SCHOOL***

What school does the adolescent attend? \_\_\_\_\_ Grade: \_\_\_\_\_

Does the adolescent enjoy school? YES NO

Does the adolescent generally complete his/her homework assignments on time? YES NO

Is working on homework or school projects a problem for the adolescent? YES NO If yes, why? \_\_\_\_\_

Is the adolescent in a special class? YES NO If yes, what class: \_\_\_\_\_

Is the adolescent having behavioral problems at school? YES NO If yes, describe: \_\_\_\_\_

Please circle the word that best describes the adolescent's grades:

Superior      Above Average      Average      Below Average      Failing

Has the adolescent missed much school? YES NO If yes, why? \_\_\_\_\_

Has the adolescent had a recent major change in academic performance? YES NO

Has the adolescent been diagnosed with a learning disability? YES NO If yes, describe: \_\_\_\_\_

**MEDICAL HISTORY**

Approximate date of the adolescent's last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name and address of her/his doctor: \_\_\_\_\_

Was the adolescent's development typical? YES NO If not, please explain: \_\_\_\_\_

Has the adolescent ever been hospitalized? YES NO If yes, for what? \_\_\_\_\_

Has the adolescent ever had an operation? YES NO If yes, for what? \_\_\_\_\_

Does the adolescent have any neurological or physical handicaps? YES NO If yes, what? \_\_\_\_\_

Was there anything remarkable about pregnancy, labor, or delivery with this adolescent? YES NO If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Were there any unusual illnesses as an infant? YES NO If yes, what? \_\_\_\_\_

Has he/she had any motor coordination, visual, speech, learning, or language problems? YES NO If yes, what? \_\_\_\_\_

**MEDICATIONS**

Is the adolescent taking medication now (including over-the-counter)? YES NO If yes, please list medicine(s), dosage, and dates taken:

\_\_\_\_\_

Has the adolescent been on any other medication within the last 6 months? YES NO If yes, please list medicine(s), dosage, and dates taken:

\_\_\_\_\_

Does the adolescent have any known medical allergies or reactions? YES NO If yes, what? \_\_\_\_\_

**LEGAL HISTORY**

Has the adolescent ever been in trouble with the law? YES NO If yes, please specify: \_\_\_\_\_

**VICTIM ISSUES**

Have you had any indications that the adolescent may have been sexually molested? YES NO If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Have you had any indications that the adolescent may have been physically abused? YES NO If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

**PERSONAL STRENGTHS AND WEAKNESSES**

Please describe the adolescent's personal strengths, talents, skills, abilities, and accomplishments: \_\_\_\_\_

\_\_\_\_\_

Please describe the adolescent's personal weaknesses and needs: \_\_\_\_\_

Describe any preferences for therapy (language, learning style, approach): \_\_\_\_\_

Other symptoms or stressors (example: physical/medical, social, family, financial): \_\_\_\_\_

**COMMUNITY ACCESS / SOCIAL SUPPORTS**

--Please put an "X" next to any of the following community supports with which you are **currently** involved.  
--On the space provided, please indicate the **name** of the individual with whom you are working, if applicable.  
--If you **would like to** be involved with a particular service/support that is listed here, please indicate that on the line provided. (This helps with transition planning and helps your therapist coordinate treatment with other professionals to provide consistent care. Your therapist will **not** contact any of these individuals without your written permission.)

- Legal services (attorney) \_\_\_\_\_
- Norfolk Rescue Mission (crisis housing) \_\_\_\_\_
- Correction services (probation or parole officer) \_\_\_\_\_
- Local church (pastor/priest) \_\_\_\_\_
- HHS case manager \_\_\_\_\_
- Liberty Centre (living &/or day services for adult mental health problems) \_\_\_\_\_
- Vocational Rehabilitation (employment assistance) \_\_\_\_\_
- Employment Works (job skill shadowing and support) \_\_\_\_\_
- Financial services (budget and debt counseling) \_\_\_\_\_
- Bright Horizons (domestic violence shelter and support) \_\_\_\_\_
- Alcoholics Anonymous or Narcotics Anonymous \_\_\_\_\_
- Al-Anon (support for family/friends of alcoholics) \_\_\_\_\_
- Community support (support/transport for mental health or substance abuse treatment) \_\_\_\_\_
- Family support (supervised visitation and education) \_\_\_\_\_
- Professional Partners (in-home planning for child/adolescent behavior problems) \_\_\_\_\_
- Parent-to-Parent Network (mentoring and peer support for parents) \_\_\_\_\_
- HUD or other housing assistance \_\_\_\_\_
- Developmental disability services (Envisions, etc.) \_\_\_\_\_
- Crisis hotline \_\_\_\_\_
- Medication management (psychiatrist or APRN) \_\_\_\_\_
- Psychological testing \_\_\_\_\_
- I.O.P. program (adolescent or adult intensive therapy for substance abuse) \_\_\_\_\_
- Community Health Care Clinic (low-income medical care) \_\_\_\_\_
- Recreation services (The Y, or other fitness facilities) \_\_\_\_\_
- Support group \_\_\_\_\_
- Physical/occupational/speech therapy \_\_\_\_\_
- Residential treatment (group home, halfway house) \_\_\_\_\_
- Rehabilitation treatment center \_\_\_\_\_
- Dietary services (nutritionist) \_\_\_\_\_
- Educational services (tutoring, after-school program) \_\_\_\_\_
- Mentoring program (Befriend, Teammates, Big Brother Big Sister) \_\_\_\_\_
- Any other services \_\_\_\_\_

\*\*\*\*\*

With my signature and date, I agree that the information in this history form is true to the best of my knowledge: \_\_\_\_\_ Thanks for your time and effort!