



TEXAS COUNSELING

Individual, Couples, Family

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ADOLESCENT INFORMATION FORM

Name _____

Date of 1st Appointment _____

Date of Birth _____

Age _____

Gender:

Male _____

Female _____

MEDICAL HISTORY

Name of Primary Care Physician:

Medications taken currently:

1) _____ Dosage/Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital

Mo/Yr

Reason

Describe any important medical history, chronic ailments, or other health problems you experience or experienced in the Past: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list:

SCHOOL AND FAMILY HISTORY

Do you experience any academic problems while in school? (Circle One) YES NO

If yes, please explain: _____

What was the last year of school you completed? _____

Name of school are you currently attending: _____

Who is in your current support network? (friends, relatives, other adults): _____

Please check **all** information which applies to your biological parents:

MOTHER	___ living	FATHER	___ living
	___ deceased		___ deceased
	___ married		___ married
	___ divorced		___ divorced
	___ remarried ___# of times		___ remarried ___# of times

With whom do you live? Mother___ Father___ Stepmother___ Stepfather___ Grandparent ___

Guardian ___

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom? _____

List first names and ages of your brothers & sisters:

Name	Age	Relationship (biological, step, half, etc.)	Lives with:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Others living in the home with you:

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Describe your relationship with your mother:

Currently: _____

In the past: _____

Describe your relationship with your father:

Currently: _____

In the past: _____

Describe your relationship with your stepmother: _____

Describe your relationship with your stepfather: _____

Describe any problems that have occurred in your family relating to:

Alcohol/drug abuse: _____

Sexual/physical/emotional abuse: _____

Please check any of the following that describe how you believe you feel:

___sad ___anxious ___depressed ___frightened ___guilty ___angry ___ashamed ___aggressive
___resentful ___worthless ___tearful ___irritable ___confused ___extreme ups/downs ___jealous
___hopeless ___helpless ___annoyed

Describe any other feelings you have had: _____

Please check any of the following risk-taking behaviors you have engaged in:

___street racing ___gang involvement ___skip school ___dropped out ___dangerous dieting ___cutting
___stealing ___unprotected sex ___running away ___bullying others ___fire starting ___hurt animals ___restrict
or restricted food intake ___over exercise

Please check any of the following alcohol/drugs that you currently or have previously used:

___beer ___wine ___hard liquor ___pot ___cocaine ___heroin ___Ecstasy ___speed ___over the counter
drugs ___prescription drugs ___Triple C's ___dones ___quad bars Other: _____

Have you had any change in sleeping habits? (Circle One) YES NO

Describe: _____

Have you had any change in eating habits? (Circle One) YES NO

Describe: _____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List any current problems you are having in daily psychological, social, or school functioning (i.e. isolation from friends/family, significant difficulty getting to school or completing daily tasks, parent's recent divorce or problems with peers, getting along with family members): _____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES NO

Describe: _____

How much time do you spend online or gaming? _____

Is there any other information regarding you or your family that you would like to share with your Therapist that is not covered on this form? You may also use this space to complete earlier responses.

Please list your therapy goals:

1. _____
2. _____
3. _____
4. _____
5. _____

THANK YOU!