MICHELLE LISKA
THERAPY

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Adolescent Personal Psychosocial History

Client Name: _____ Age of Client: _____

Person (if any) completing form for client: _____

Relationship to client: _____

THANK YOU for taking your time to complete this form. The form is long, but the more information you provide will help your therapist better understand you. You may also use the back of this form if necessary.

Please tell me what recently occurred that caused you to seek help now?

_____

_____

	First Name	Age	Living with you? (Yes/No)	If deceased, year & cause
Father				
Mother				
Stepfather				
Stepmother				
Spouse/boy-/girlfriend				
Siblings--biological (oldest to youngest)				

Siblings--half (please state mom or dad's side of family)				
Siblings--step (please state mom or dad's side of family)				

Who is primarily raising you? _____
(If adopted, please describe the adoption on the back of this sheet)

Parents' current marital status: _____

If parents are divorced, how old were you at the time of the divorce? _____

If parents divorced and remarried, how old were you at the time of the remarriage(s)?

_____

Which of your family members would you say you are closest to now?

_____

Pregnancy & Delivery Information

Was this a planned pregnancy? Y or N

Any pregnancy complications? Y or N If yes, please explain: _____

Was pregnancy full term? Y or N If delivery was premature, how early? _____

Type of delivery (natural, Cesarean section, forceps, etc.): _____

Was oxygen necessary upon delivery? Y or N Blood transfusion upon delivery? Y or N

Did infant require an electroencephalogram (EEG)? Y or N

Any difficulty with any of the following (please circle):

Jaundice Blue lips Colic Nursing difficulty Other feeding difficulty

Deformation Seizures Slow to respond High fever

Developmental Information

Normal weight gain as an infant/toddler? Y or N

Any of the following (please circle):

Head banging Rocking Thumb sucking Teeth grinding Tantrums

What age did child:

Sit up _____ Use words _____ Walk _____

Toilet train _____

Any difficulty for child to form attachments? Y or N If yes, please explain:

_____

Cultural Background

How do you self-identify your race and ethnicity? _____

How do you self-identify your sexual orientation (asexual, homosexual, bisexual, heterosexual, queer, pansexual, polyamorous, other)?

How do you self-identify your gender (female, male, cisgender, fluid, transgender/trans, other)?

Religious preference: _____

Are your currently active in your religion? (Circle one) / Yes / Somewhat / No

In what language do you prefer to communicate? _____

Were you and both your biological parents born in the USA? (Circle one) / Yes / No / Unsure

Educational Background

What grade did you complete last or are you currently attending ? ___

What school do you currently attend? _____

What schools have you attended?

_____

_____

_____

_____

Medical Information

Have you ever been hospitalized? (If so, for what reason?)

_____

Do you have any major health problems (please list)?

_____

_____

Primary Physician's Name: _____ Phone: _____

Physicians Address: _____

Date of your last physical: _____ Results: _____

Please list any medications that you are currently on and the illnesses they are treating:

_____

_____

Do you skip meals often? _____ Do you eat a well balanced diet? _____

Have you ever struggled with disordered eating/an eating disorder?
_____

Do you exercise regularly? _____ How often? _____ What type of exercise? _____

For females

Do you have a normal menstrual cycle? _____ Are you currently pregnant? _____

Do you experience premenstrual syndrome (PMS)? _____Are you currently taking birth control? _____

R Check here if you or your family members (family of origin and current family members) DO NOT have a history of any substance use disorder(s). If you check this circle, please proceed to the bottom of page 6, "Employment"section of this form, and continue.

Chemical Use History

Tobacco

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Alcohol

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Marijuana

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Prescription or over the counter (OTC) medication use/abuse (using prescription medication that was or was not your prescription to get high; using OTC medication to get high)

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Caffeine (coffee, caffeinated sodas, energy drinks, tea)

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____
If you used to use this substance, when and why did you quit using? _____

Cocaine (all forms)

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Heroin/opioids
Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Methamphetamine

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Hallucinogens

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Inhalants (huffing)

Use (Y or N): ____ How did you use it: _____ Age of 1st use: _____

Date most current use: _____

Current use daily/weekly: _____ Length of current amount of use: _____

Period of heavy use (age, how long, how much): _____

If you used to use this substance, when and why did you quit using? _____

Chemical use associated problems (answer Y or N):

Blackouts _____

Unable to stop after repeated attempts _____

Increased tolerance _____

Family/friend concerns _____

Chemical use withdrawal symptoms (answer Y or N):

Nausea _____

Vomiting _____

Other addiction behaviors (answer Y or N):

Compulsive overeating _____

Internet _____

Shoplifting/stealing _____

Past and Current Substance Use Disorder Treatment

History of substance abuse treatment (answer Y or N): _____

Current/past participation in support (12-step or other) groups (answer Y or N): _____

Family history of use of substance use disorder(s):

Have any family members of yours had a problem with a substance use disorder(s)? _____

Who? _____

Please explain:_____

Employment

Are you working outside of school? _____
_____

Current employer: _____

How long at this job: _____Have you ever been fired from a job? _____

Why? _____

Do you have any problems with your current job? _____

Legal History

Have you ever gotten in trouble with law enforcement? _____

Were you arrested or charged with anything? _____

Date(s): _____

Have you been on probation? _____ Dates of probation _____

Problem Checklist (Check any symptoms that apply whether problem heading is correct or not)

Depression

Chronic sadness		Low frustration tolerance		Hopelessness	
Crying episodes		Irritability		Sleep problems	
Difficulty concentrating		Memory problems		Weight loss	
Thoughts of suicide		Weight gain		Withdrawing from others	
Loss of appetite		Difficulty functioning at work		Overeating	
Difficulty socially		Nausea/Vomiting		Low energy/fatigue	

Difficulty making decisions		Reduced interest in hobbies		Reccurring thoughts of death	
Feelings of worthlessness/guilt					

Anxiety

Agitation		Restlessness		Excessive worry	
Fearfulness		Trembling/Shaking		Fear of loss of control	
Fear of dying		Panic attacks		Fear of leaving home	
Avoidance of public places		Avoidance of social situations		Chest pain	
Shortness of breath					

Stress/Trauma

Feelings of detachment		Intrusive bad memories		Upsetting flashbacks	
Nightmares		Easily startled/upset			

Eating Problems

Excessive Eating		Underweight		Use of laxatives	
Eating interfering with health		Obesity		Self-induced vomiting	
Obsessing about diet					

Thinking Problems

Hearing voices others do not		Excessive self-consciousness		Fear others are plotting against you	
Seeing things others do not					

Attention and Behavior

Difficulty completing tasks		Difficulty focusing		Tendency to be impulsive	
Unorganized		Problems with co-workers		Problems with authorities	
Taking on too many tasks		Frequent forgetfulness		Difficulty with patience	

Other Problem Areas

Racing thoughts		Excessive spending		High risk sexual behavior	
Worried about sexual behavior		Serious parent-child conflicts		Insomnia/lack of sleep	
Excessive gambling		Abuse towards others		Serious marital conflicts	
Frequent family conflicts					

Which of the above concerns are most **important** to you?

Most important: _____

Second most: _____

Third most: _____

Mental Health History

Have you been in counseling/behavioral or mental health therapy before? _____

When and where? _____

Do you have a pre-existing mental health diagnosis? If so, what is the diagnosis?

_____

Do any of your family members have a mental health diagnosis? If so, what family member and what is the diagnosis/diagnoses?

_____

Have you ever had any thoughts of harming yourself or wishing you were dead? (If so, have you experienced these thoughts recently? Explain)

_____

Have you ever attempted to commit suicide or seriously harm yourself? (If so, please explain when, how, and why)

_____

_____

Have you ever been psychiatrically hospitalized? _____

Has anyone in your family ever attempted to commit suicide? _____ Who? _____

Please explain _____

Have you ever abused any of your loved ones? _____ Who? _____

Have you ever been the victim of physical, sexual, or verbal abuse (as a child or as an adult)?

_____

Summary
Please feel free to explain any thoughts or feelings about previously checked items:

_____

_____

_____

_____

_____

The above information is given freely and is true to the best of my knowledge.

I understand that no information about me or my treatment will be divulged to any person outside of counseling without my written consent, with the following exceptions: 1)in the event that there is clear and imminent threat of harm toward me or against another person; 2) if there is intent to commit criminal activity or awareness or suspicion of such toward a minor or an elder; and 3) if a court order requiring your testimony, under legal consultation, in response to my raising the issue of mental health in a lawsuit or when minors have limited rights of confidentiality.

Date: _____ _____

Signature