# Adolescents and Teens Assessment

## Demographic Information

Date: _____
Patient Name: _____
Name of person completing form: _____
Relationship to patient: _____
Patient Date of Birth: _____
Home Address: _____
_____
Phone number: _____
Email: _____
**Referred by:** _____

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## Insurance/Billing Information

Insurance Company Name: _____
Policy or ID number: _____
Group number: _____
Name of Policy Holder: _____
Address and Phone Number of Policy Holder (if different from above):
_____
Policy Holder's Date of Birth: _____

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## Parent Consent

We **MUST** have at least one parent signature, **EXCEPT** in cases where parents of a patient are divorced; both parents must consent at the start of treatment. No further sessions will be held unless both parents consent to the patient receiving treatment at Hope Restored Services, in accordance with Florida law.

_____
Mother's signature

_____
Father's signature

## Patient History

Please state the presenting problem:
_____
_____
_____

How long has this problem existed: _____

Please name the people who reside in your home:

| Name | Age | Occupation |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has the patient ever suffered abuse? Yes No
If so, what kind? Physical Sexual Neglect
If so, was the abuse ever reported to authorities? Yes No
Has the patient ever witnessed domestic violence in the home? Yes No
Is domestic violence currently occurring in the child's home? Yes No
Current or previous DCF involvement? Yes No
If yes, please explain:

_____
_____

What extracurricular activities does the patient engage in at this time?

_____

Has he or she ever been employed? Yes No

## Educational History

School Name Grade

_____ _____

List any grades repeated by the patient: _____

Behavioral difficulties? Yes No If yes, please describe:

_____

Difficulties with academics? Yes No If yes, please describe:

_____

Does the patient have an Individualized Education Plan (IEP)? Yes No

If yes, do you know the reason for the IEP (i.e. learning disability)?_____

## Medical History

Patient's birth weight and height: _____
Was the patient adopted? Yes No
Method of delivery: Vaginal Cesarean
Complications at birth: Yes No
If yes, please explain: _____
Did the patient meet developmental milestones on time: Yes No
If no, describe below:

_____

Current medical concerns: _____

## Psychiatric History and Symptom Inventory

List the patient's three most stressful issues as reported by the patient:

1. _____
2. _____
3. _____

Does the patient have a history of receiving mental health counseling, behavioral therapy, inpatient psychiatric care, or outpatient medication management by a psychiatrist or neurologist?

Yes No If so, please list below:

Name of Provider Dates of Service

_____ _____

_____ _____

Family psychiatric history:

_____

_____

Psychiatric medication history: Please list below the medications that the patient has been prescribed for psychiatric reasons. Place an asterisk (*) next to those that the patient is currently taking.

| Medication | Dosage | Duration on medicine |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has the patient ever attempted to commit suicide? Yes No
If yes, please describe: _____

Is the patient currently experiencing suicidal thoughts? Yes No
If yes, please describe: _____

Current Symptoms (circle all occurring in the last two weeks)

| | | | |
|---|---|---|---|
| Sleep disturbance | Anxiety/Worry | Sadness | Problems with friends |
| Appetite changes | Crying more than normal | Social isolation | Hopelessness |
| Poor concentration | Apathy | Trouble making decisions | Anger/hostility |
| Fatigue/Lack of energy | Unable to sit still | Hearing voices | Poor self esteem |

Please describe symptoms not listed in the table above:

_____

_____

## Legal History

Has the patient ever been arrested or involved in any type of legal proceeding?
Yes No

If yes, please explain: _____

## Substance Abuse History

Does the patient have a history of any substance abuse? Yes No

If so, please list the substances and the patient's treatment history:

_____

_____

_____