NORTHWEST HEALTH SERVICES

Northwest Health Services
Adolescents Health History Form
Ages 13-17

**Please complete this form about you**. It will help your counselor understand why you are here and what kind of trouble you are having. Please take your time. If you have questions do the best you can and the counselor will go over this form with you.

| Name: | | Date: |
|---|---|---|
| Date of Birth: | Your Age: | |
| Name of Parent or Guardian who brings you to visit: | | |

Was it your idea to come here today? ☐ Yes ☐ No If not, who recommended it?_____
Why do they feel it was needed?_____
How do you feel about coming here?_____
What do you think the problem is?_____

**What do you like to do?**

| | | |
|---|---|---|
| ☐ Hang out with friends | ☐ Play sports or exercise | ☐ Listen to music |
| ☐ Sing or dance | ☐ Write | ☐ Sleep a lot |
| ☐ Read | ☐ Be with boyfriend or girlfriend | ☐ Draw |
| ☐ Get into trouble | ☐ Diet | ☐ Stay to myself |
| ☐ Eat | ☐ Talk on the phone | ☐ Nothing |
| ☐ Just about anything | ☐ Do things with family | ☐ Baby-sit |
| ☐ Build or fix things | ☐ Play an instrument | ☐ Get high |
| ☐ Drink | ☐ Go shopping | ☐ Play video games |
| ☐ Skate board | ☐ Fish | ☐ Go to school |
| ☐ Pray or go to church | ☐ Watch Television | ☐ Text |
| ☐ Camp | ☐ Snapchat | ☐ Twitter |
| ☐ Be out doors | | ☐ Facebook |
| ☐ Go for a drive | | |

Are there other things you like to do besides what is listed above? _____
_____
Are there other things you used to enjoy doing but lately do not want to do them? ☐ Yes ☐ No
If yes, what are they?_____
What do you hate doing?_____
What chores or responsibilities do you have at home?_____

Do you have spiritual beliefs? ☐ Yes ☐ No If yes, what are they?_____
_____

Do you pray? ☐ Yes ☐ No Do you go to church? ☐ Yes ☐ No

**Employment**

Do you have a job or volunteer? ☐ Yes ☐ No If yes, Where?_____
How many hours do you work each week?_____ Do you like it? ☐ Yes ☐ No

**School/Education**

What grade are you in?_____ What school do you attend?_____

How do you do in school?_____

Are you doing your best? ☐ Yes ☐ No If not, why not?_____

What are your favorite classes?_____

What are the classes you don't like?_____

Have you ever been bullied? ☐ Yes ☐ No If yes, Tell us about it._____

Are you popular with your classmates? ☐ Yes ☐ No If not why not? _____

**How I feel**

Please check any of the items that apply to you now or in the past 6 months

| | | |
|---|---|---|
| ○ Depression | ○ Seeing things others don't | ○ Purging |
| ○ Crying spells | ○ Unusual thoughts | ○ Yelling or breaking things |
| ○ Hopelessness | ○ More alcohol than usual | ○ Hitting people |
| ○ Relationship Break-up | ○ More drugs than usual | ○ Endangering yourself |
| ○ Loneliness | ○ Blackouts or memory loss | ○ Endangering others |
| ○ Emptiness | ○ Withdrawal from Substances | ○ Feeling controlled |
| ○ Loss of Appetite | ○ Mood swings | ○ Feeling talked about |
| ○ Trouble sleeping | ○ Racing thoughts | ○ Feeling guilty or ashamed |
| ○ Thoughts of harming yourself | ○ Fear of dying | ○ Paranoia |
| ○ Poor/bad decisions | ○ Job stress | ○ Loss of _____ |
| ○ Feeling nervous or anxious | ○ Less activity than normal | ○ Sexual problems |
| ○ Panic attacks | ○ Not seeing friends (isolating self) | ○ Problems with school or job |
| ○ Can't concentrate | ○ Worrying | ○ Feeling intimidated |
| ○ Confusion | ○ Fear of loss | ○ Violence or fear in the home |
| ○ Thoughts of harming others | ○ Loss of control of alcohol or drug use | ○ Nightmares |
| ○ Suicide attempts or injuries | ○ Overeating | ○ History of abuse |
| ○ Hearing voices | ○ Binging | ○ _____ |

**Your feelings**

Name some things you like about yourself: _____

Name some things you don't like about yourself:_____

Name some things you worry about: _____

_____

What makes you happy or feel good about yourself? _____

_____

What makes you feel sad? _____

What makes you feel angry? _____

Who are you closest to in your family? _____

Is there anyone you don't get along with in your family? ☐ Yes ☐ No

Why don't you get along? _____

Have you ever thought of running away or actually ran away? ☐ Yes ☐ No If yes what made you feel that way?

_____

Have you ever wished you were dead? ☐ Yes ☐ No If yes, when?_____

What made you feel that way?_____

Have you felt like dying or hurting yourself in the last few weeks? ☐ Yes ☐ No If yes, what made you feel that way?

_____

Did you ever make a plan to hurt yourself? ☐ Yes ☐ No If yes, what was it? _____

Did you ever hurt yourself on purpose? ☐ Yes ☐ No If yes, when and what did you do? _____

_____

Have you known someone who committed suicide? ☐ Yes ☐ No If yes, who was it and when?_____

Do you think of hurting other people or animals? ☐ Yes ☐ No

Have you ever actually hurt other people or animals? ☐ Yes ☐ No If yes, what did you do?_____

_____

Name 3 things in life that upset or bother you the most:

1. _____
2. _____
3. _____

## My Support System

Have you ever seen a counselor in school? Yes No If yes, when and why?_____

_____

Do you feel it was helpful? ☐ Yes ☐ No If not why wasn't it?_____

_____

Have you ever seen a counselor outside of school? ☐ Yes ☐ No If yes, when and why? _____

_____

Do you feel it was helpful? ☐ Yes ☐ No If not why wasn't it?_____

_____

Do you have someone you can talk to when something is bothering you? ☐ Yes ☐ No

## Chemical Dependency

Do you smoke? ☐ Yes ☐ No If yes, how many a day? _____

Have you ever drank alcohol? ☐ Yes ☐ No If yes, how often and when? _____

_____

Have you ever gotten high? ☐ Yes ☐ No If yes, how often and when?_____

_____

Patient Name_____ Date of Birth_____

Do you drink or get high now? ☐ Yes ☐ No How many days a week?_____

What do you get high on? _____

What did you get high on or have used in the past?_____

How do your parents feel about you getting high?_____

**Sexual Activities**

Have you ever or are you currently sexually active? ☐ Past ☐ Currently ☐ Practicing Safe Sex

**Legal**

Have you ever been in trouble with the law? ☐ Yes ☐ No If yes what did you do and when?_____

_____

The Juvenile Office ☐ Yes ☐ No If yes, when and what did you do?_____

_____

Have you ever been on probation? ☐ Yes ☐ No If yes, when and what did you do?_____

_____

Patient Signature:_____ Date:_____

*Reviewed by: Therapist/Provider Signature*_____ *Credentials*_____ *Date*_____