

CONNECTION COUNSELING

ADOLESCENT REGISTRATION FORM

PERSONAL INFORMATION

Name _____ Date of first appt. _____

Current Street Address _____

City _____ State _____ Zip _____

Age _____ Date of Birth _____ Social Security Number _____

Ethnic Origin _____ Sex _____ Telephone _____

Church Preference _____ Referral Source _____

School _____ Grade _____

Parent/Responsible Part bringing this minor for counseling _____

Relationship to the Child/Adolescent _____

Please list the name and relationship to minor of anyone that we may speak to regarding appointments or billing only: _____

PERSONAL INFORMATION ON PARENTS/STEP PARENTS/GUARDIANS

Biological or Adoptive Father's Name _____

Date of Birth _____ Living in the Household Yes No

Home Phone _____ Work Phone _____

Marital Status _____ How long have you been married? _____ Number of Marriages _____

Highest Grade Completed: 9th 10th 11th 12th College Post-Graduate

Ethnic Origin _____ Military service: Yes No Branch of service: _____

Current Employer _____ Occupation _____

In case of emergency may we contact you at your place of employment? Yes No

Contact person in case of an emergency _____ Phone _____

Biological or Adoptive Mother's Name _____

Date of Birth _____ Living in the Household Yes No

Home Phone _____ Work Phone _____

Marital Status _____ How long have you been married? _____ Number of Marriages _____

Highest Grade Completed: 9th 10th 11th 12th College Post-Graduate

Ethnic Origin _____ Military service: Yes No Branch of service: _____

Current Employer _____ Occupation _____

In case of emergency may we contact you at your place of employment? Yes No

Contact person in case of an emergency _____ Phone _____

Children's Names	Age	Relationship to child	
_____	_____	_____	Living in Household <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	Living in Household <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	Living in Household <input type="checkbox"/> Yes <input type="checkbox"/> No

Others living in the household: _____

Step-parent or guardian for the adolescent:

Name _____ Relationship to child _____

Living in the household with the client? Yes No Telephone _____

Date of Birth _____ Sex _____ Ethnic Origin _____

Employer _____ Telephone _____

RESIDENCE HISTORY

List places the adolescent has lived in the past five years:

Has the student attended different schools because of change of residence? _____

MEDICAL HISTORY OF ADOLESCENT

Major Illnesses _____

Surgical History _____

Traumas to head, unconsciousness, seizures, high fevers _____

Drug Sensitivities/Allergies _____

Please list prescriptions, over the counter medications or diet supplements taken within the last six months. Also list the prescribing physician as well as the medical reason for taking this medication.

Date last seen by physician/name: _____

ALCOHOL AND OTHER DRUG HISTORY

Present use of alcohol (amount/frequency) _____

Past use of alcohol (amount/frequency) _____

Present use of illicit drugs (type/amount/frequency) _____

Past use of illicit drugs (type/amount/frequency) _____

How much caffeine do you drink in a day? _____

Do you presently use tobacco products? If so, please specify type/frequency _____

TRAUMA HISTORY

Has your child experienced sexual, physical, or emotional abuse? Have there been any recent deaths within the family? Is alcoholism present within the family?

EMOTIONAL HEALTH HISTORY OF FAMILY

Identify any previous counseling (date/place/inpatient or outpatient/reason): _____

FAMILY OF ORIGIN MEDICAL HISTORY

Provide information concerning major physical or emotional illnesses suffered by your family members. _____

OTHER PERTINENT INFORMATION

Court actions pending: probation, DUI, custody, other: _____

ADADEMIC & SOCIAL HISTORY OF CHILD

List schools your child has attended up to the present time: _____

How does your child feel about school? _____

Have there been any grades repeated? If so, which ones? _____

Mention any behavior problems your child has had at school. _____

What kind of grades does your child receive in school? _____

Does your child belong to any organized activities such as scouts, sports, band, etc. _____

What is your child's dating habits in his/her relationship with the opposite sex? _____

PRESENTING PROBLEM

Describe your current reasons for seeking counseling: _____

What results do you hope to achieve through counseling? _____

Client Signature _____ Date _____

Parent/Guardian Signature _____