Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

ADOLESCENT TO COMPLETE – Ages 13-18

Dx code: _____

We understand that some of these questions may be difficult to answer or may not apply to you. Please do the best you can at answering these questions. The answers you give will help us to better understand where you are so we can help guide you during these life struggles.

Your Name: _____

Street Address: _____ City, State, Zip:_____

Can we write you here? Yes / No

Home Phone: _____ Cell Phone: _____

Can we leave a message? at Home: Yes / No Cell: Yes / No

Can we text you on your cell phone? Yes / No

Email: _____

Can we email you here? Yes / No

Birthday: _____

School :_____ Grade _____

Favorite class: _____

Hobbies _____

Who do you currently live with? _____

What is their relationship to you? _____

Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

MEDICAL INFORMATION

How would you rate your current physical health? □ Excellent □ Good □ Fair □ Poor
Are you currently experiencing any physical problems (e.g. headaches, body aches, stomach problems)?

□ Yes □ No If yes, please explain: _____

Previous hospitalizations for medical reasons Date:_____ Reason: _____

Medical conditions or disabilities: _____

Learning or other disabilities not listed: _____

Have you ever had an abortion? □ Yes □ No If yes, how many? _____ when?_____
Are you currently sexually active? □ Yes □ No

If yes, how many current sexual partners? _____

Same sex or opposite sex? □ Opposite □Same Have they experimented with same sex? □ Yes □ No

Please list all non-psychiatric medications: (over the counter or prescription):

Medication	Dosage	Frequency	Reason for taking

Have you ever abused non-prescription drugs? □ Yes □ No

If yes, which types and when? _____

Have you ever abused prescription drugs? □ Yes □ No

If yes, which types and when? _____

Have you ever abused alcohol? □ Yes □ No

If yes, which types and when? _____

Have you ever abused tobacco? □ Yes □ No

If yes, which types and when? _____

To your knowledge, has either of your parents had medical problems? □ Yes □ No

If yes, Please explain: _____

COUNSELING AND PSYCHIATRIC INFORMATION

Have you had previous counseling? □ Yes □ No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

What were the results?_____

Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

To your knowledge, have you ever been diagnosed or treated for any type of mental illness? □ Yes □ No

If yes, which type? _____

Please list any other disorders not already mentioned:_____

To your knowledge, has anyone in your family ever been diagnosed with or treated for any type of mental illness?

□ Yes □ No If yes, which type? _____

Have you ever attempted to complete homicide? □ Yes □ No
If yes, When? _____how? _____
What action was taken? _____
Have you ever attempted to complete suicide? □ Yes □ No
If yes, When? _____how? _____
What action was taken? _____
To your knowledge, is there a history of suicide in your nuclear or extended family? □ Yes □ No
If yes, Who? _____when? _____

Are you presently having thoughts of harming self or others? □ Yes □ No

If yes, explain _____

Are you presently self-harming by cutting yourself? □ Yes □ No

If yes, explain _____

Please list all psychiatric medications:

Medication	Dosage	Frequency	Reason for taking

FAMILY RELATIONSHIPS

If parents are separated or divorced, how old were you when this occurred? _____

How did you handle or are handling the separation or divorce? _____

_____

Are there difficulties within your family now? □ Yes □ No
If yes, do you think these difficulties are contributing to your behavior? □ Yes □ No
If yes, please explain _____

_____

_____

Which family member are you the closest? _____

Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

How do you get along with your brothers and/or sisters? _____

_____

Describe any special activities that you do with your family and frequency of that activity:_____

_____

THOUGHTS CHECKLIST

Please check how often the following thoughts that occur to you:

1.	Life is hopeless.	___	Never	___	Rarely	___	Sometimes ___ Frequently
2.	I am lonely.	___	Never	___	Rarely	___	Sometimes ___ Frequently
3.	No one cares about me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
4.	I am a failure.	___	Never	___	Rarely	___	Sometimes ___ Frequently
5.	Most people don't like me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
6.	I want to die.	___	Never	___	Rarely	___	Sometimes ___ Frequently
7.	I want to hurt someone.	___	Never	___	Rarely	___	Sometimes ___ Frequently
8.	I am so stupid.	___	Never	___	Rarely	___	Sometimes ___ Frequently
9.	I am going crazy.	___	Never	___	Rarely	___	Sometimes ___ Frequently
10.	I can't concentrate.	___	Never	___	Rarely	___	Sometimes ___ Frequently
11.	I am so depressed.	___	Never	___	Rarely	___	Sometimes ___ Frequently
12.	God is disappointed in me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
13.	I am disappointed with God	___	Never	___	Rarely	___	Sometimes ___ Frequently
14.	I can't be forgiven.	___	Never	___	Rarely	___	Sometimes ___ Frequently
15.	Why am I so different?	___	Never	___	Rarely	___	Sometimes ___ Frequently
16.	I can't do anything right.	___	Never	___	Rarely	___	Sometimes ___ Frequently
17.	People hear my thoughts.	___	Never	___	Rarely	___	Sometimes ___ Frequently
18.	I have no emotions.	___	Never	___	Rarely	___	Sometimes ___ Frequently
19.	Someone is watching me.	___	Never	___	Rarely	___	Sometimes ___ Frequently
20.	I hear voices in my head.	___	Never	___	Rarely	___	Sometimes ___ Frequently
21.	I am out of control.	___	Never	___	Rarely	___	Sometimes ___ Frequently

Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

ISSUES CHECKLIST

Please indicate which of the following are **current** issues for you. Check all that apply:

__ Not being able to say what you really think or feel
__ Under too much pressure and feeling stressed
__ Feeling down or unhappy/depressed mood
__ Excessive anxiety or worry
__ Withdrawing from others
__ Suspicious feelings toward other people
__ Afraid of being on your own
__ Angry feelings
__ Concerns about finances
__ Feeling "numb" or cut off from emotions
__ Concerns about physical health
__ Concerns about emotional stability
__ Tremors
__ Blackouts or temporary loss of memory
__ Insomnia (not being able to sleep)
__ Loss of appetite/increased appetite
__ Uncontrollable anxiety or worry
__ Lacking self-confidence
__ Feeling sexually attracted to members of your own sex
__ Eating and then vomiting to control weight
__ Excessive use of alcohol
__ Abuse of non-prescription drugs
__ Loss of interest in usual activities/lack of motivation
__ Heart Palpitations
Other: _____

__ Feeling inferior to others
__ Angry outbursts
__ Excessive fear of specific places or objects
__ Difficulty making friends
__ Difficulty keeping friends
__ Feeling as if you'd be better off dead
__ Feeling manipulated or controlled by others
__ Difficulty making decisions
__ Loss of interest in sexual relationships
__ Feeling Fat
__ Feeling distant from God
__ Hallucinations
__ Hypersomnia (sleeping all the time)
__ Inability to concentrate while at school/work
__ Crying spells
__ Feeling "on top of the world"
__ Nightmares
__ Getting into trouble at school/work
__ Obsessions or compulsions with specific activities
__ Inability to control thoughts
__ Feeling trapped in rooms/buildings
__ Hearing voices
__ Feeling that people are "out to get you" or that you are being watched
__ Memory Problems
__ Chest Pain/Pressure

PROBLEMS CHECKLIST -

Rate Each Issue with a Number: 1 = Major Problem 2 = Problem at Times 3= Not a Problem

_____ Feeling accepted by my peers
_____ Getting along with my parents or other family members
_____ Dealing with sexual feelings and/or problems
_____ Trying to decide on a career
_____ Learning how to trust others
_____ Getting a clear sense of what I value
_____ Worrying about my future
_____ Dealing with alcohol or drug abuse

Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

_____ Dealing with problems at school _____ Dealing with how I feel about myself

Other problems I'd like to talk about: _____

_____

What do you hope to gain from counseling? _____

_____

STRENGTHS AND HELPS

What personal strengths do you feel you possess that may help you with your current difficulties?

_____

_____

Who or what has helped you cope with your current difficulties? _____

_____

Who or what has helped you cope with past difficulties? _____

_____

SPIRITUALITY

Do you believe in God? Yes No What is your religious preference? _____

Are you a member of a church? Yes No If yes, which church? _____

How much influence does your religion or spirituality have on your day-to-day activity?

a great deal □ moderate amount □ little □ none

Do you believe that:

Absolute moral truth exists Yes No Not sure

The Bible is totally accurate in the principles that it teaches Yes No Not sure

Satan is considered to be a real being or force, not merely symbolic Yes No Not sure

A person cannot earn their way into Heaven by trying to be good or do good works Yes No Not sure

Jesus Christ lived a sinless life on earth Yes No Not sure

God is the all-knowing, all-powerful Creator of the world who still rules the universe today Yes No Not sure

Resource: The Barna Group

If you would die today, would you go to heaven? Yes No Not sure

Lunday Counseling Center

4100 Legendary Dr., Suite 220, Bldg A
Destin, FL 32541
850-424-5515

Let's say you did die today and you were standing before God and God asked you, "Why should I let you into My heaven?", what would you say? _____

_____

_____

_____

Thank you so much for choosing Lunday Counseling Center.