

Lunday Counseling Center

4300 Legendary Dr., Suite 218, Bldg C
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? _____

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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? _____

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

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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? _____

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

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

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 Feeling inferior to others

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- | | |
|--|---|
| <input type="checkbox"/> Under too much pressure and feeling stressed | <input type="checkbox"/> Angry outbursts |
| <input type="checkbox"/> Feeling down or unhappy/depressed mood | <input type="checkbox"/> Excessive fear of specific places or objects |
| <input type="checkbox"/> Excessive anxiety or worry | <input type="checkbox"/> Difficulty making friends |
| <input type="checkbox"/> Withdrawing from others | <input type="checkbox"/> Difficulty keeping friends |
| <input type="checkbox"/> Suspicious feelings toward other people | <input type="checkbox"/> Feeling as if you'd be better off dead |
| <input type="checkbox"/> Afraid of being on your own | <input type="checkbox"/> Feeling manipulated or controlled by others |
| <input type="checkbox"/> Angry feelings | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Concerns about finances | <input type="checkbox"/> Loss of interest in sexual relationships |
| <input type="checkbox"/> Feeling "numb" or cut off from emotions | <input type="checkbox"/> Feeling Fat |
| <input type="checkbox"/> Concerns about physical health | <input type="checkbox"/> Feeling distant from God |
| <input type="checkbox"/> Concerns about emotional stability | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Hypersomnia (sleeping all the time) |
| <input type="checkbox"/> Blackouts or temporary loss of memory | <input type="checkbox"/> Inability to concentrate while at school/work |
| <input type="checkbox"/> Insomnia (not being able to sleep) | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Loss of appetite/increased appetite | <input type="checkbox"/> Feeling "on top of the world" |
| <input type="checkbox"/> Uncontrollable anxiety or worry | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Lacking self-confidence | <input type="checkbox"/> Getting into trouble at school/work |
| <input type="checkbox"/> Feeling sexually attracted to members of your own sex | <input type="checkbox"/> Obsessions or compulsions with specific activities |
| <input type="checkbox"/> Eating and then vomiting to control weight | <input type="checkbox"/> Inability to control thoughts |
| <input type="checkbox"/> Excessive use of alcohol | <input type="checkbox"/> Feeling trapped in rooms/buildings |
| <input type="checkbox"/> Abuse of non-prescription drugs | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Loss of interest in usual activities/lack of motivation | <input type="checkbox"/> Feeling that people are "out to get you" or that you are being watched |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Memory Problems |
| Other: _____ | <input type="checkbox"/> 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 | _____ Learning how to trust others |
| _____ Getting along with my parents or other family members | _____ Getting a clear sense of what I value |
| _____ Dealing with sexual feelings and/or problems | _____ Worrying about my future |
| _____ Trying to decide on a career | _____ Dealing with alcohol or drug abuse |
| _____ 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? _____

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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

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.

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