

Miriam Lieberman, MA, LPCS
Integral Counseling Services
1920 Western Trail
Chapel Hill, NC 27516
(919) 304-5754

121 S. Estes Dr.
Suite 205-D
Chapel Hill, NC 27514

Teenager Initial Meeting Information

Please fill out this questionnaire in as much detail as you feel comfortable. There may be things you do not know or cannot remember. That is fine. If you need to use the back or additional paper in answering a question, go right ahead. This is NOT a test. It is one way to get to know you. Only answer what you are ready to answer. Thanks!

Date: _____

Client Name: _____

Address: _____

Email Address (optional): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax Number: _____

School: _____

Client SS# _____

Date of Birth: _____ Age: _____

Physician: _____ Psychiatrist: _____

Medication(s): _____

Referred by: _____

Notify in Case of Emergency: _____

Relationship : _____

Daytime phone: _____

Insurance Coverage: _____yes _____no Company: _____

Policy Number: _____ Diagnostic Code: _____

Insured's Name : _____ and DOB: _____

Insured SS#: _____

Background History

Have you talked with a counselor before? ____yes ____no

If yes, where? ____ School Guidance Counselor

____Mental Health Clinic

____Private Therapist

____In-Patient Hospitalization

____Other (please specify) _____

Are your Parents? ____Married ____Separated ____Divorced

____Father Deceased ____Mother Deceased ____Father Remarried ____Mother Remarried

Father's Job _____ Mother's Job _____

Were you adopted? _____ Did you experience foster care? _____

Mention anything significant about your relationship with your parents or caregivers:

Education of Father:

____Did not finish high school

____High school graduate

____Did not finish college

____Graduate degree

Education of Mother:

____Did not finish high school

____High school graduate

____Did not finish college

____Graduate degree

Number of Brothers: ____

Older: ____

Younger: ____

Half: ____

Number of Sisters: ____

Older: ____

Younger: ____

Half: ____

Where are you in the birth order? ____

Mention anything significant about your relationship with your siblings: _____

Is there anyone else that played a significant role in your early family life (grandparents, aunts, uncles, family friends...)? If so, please elaborate: _____

What form(s) of discipline are used in your family? _____

Who disciplines you? _____

How is your home life? _____

What do you like most about your family? _____

What do you dislike most about your family? _____

Is there anything else you feel is important that has not been covered so far? _____

Have you ever been to court? ____yes ____no

If yes, for what reason? _____

Have you ever been convicted for a crime? _____yes _____no

Do you consider yourself as having a problem with drugs or alcohol? ____yes ____no

Does anyone else consider your use of alcohol or drugs problematic? ____yes ____no

Has anyone in your family ever experienced substance abuse problems? ____yes ____no

Please mark the following:

	Never Used	Stopped Using	Less than 3 Times/Week	More than 3 Times/Week
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Your use of alcohol _____

Your use of marijuana _____

Your use of cocaine _____

Your use of other drugs _____

(i.e. amphetamines, tranquilizers,
hallucinogens)

Have you ever had an unwanted sexual experience (e.g. fondling, intercourse, rape, sexual harassment, etc.)? ____yes ____no

If yes, check all that apply:

____family member _____date or acquaintance

____friend _____stranger

____other (please specify)

Do you ever refuse food, overeat, hide food or purge food? ____yes ____no

If yes, check all that apply:

____uncontrollable eating _____laxative use

____rigid dieting _____other weight concerns

____self-induced vomiting _____repeated fasting

Do you have any feelings that you wish you could change? Please describe:

Do you have any behaviors that you wish you could change? Please describe:

Please name any big changes in your life within the last six months to a year:

Who can you count on for support? _____

Describe your home environment today? _____

What are your goals for counseling? _____

Emotional and Social Inventory

Circle the number that best fits your experience:

1 2 3 4 5
None A little Some Much Very Much

Social Life and Relationship Skills

Too little social life	1	2	3	4	5
Too much social life	1	2	3	4	5
Difficulty saying "no" to others	1	2	3	4	5
Difficulty meeting people	1	2	3	4	5
Have hard time with close relationships	1	2	3	4	5
Concerned about being racially harassed	1	2	3	4	5
Concerned about my sexual behavior	1	2	3	4	5
Difficulty communicating	1	2	3	4	5
Inability to make or keep friends	1	2	3	4	5
Hurting people's feelings	1	2	3	4	5
Feel like I don't fit in anywhere	1	2	3	4	5
Am considering ending a close relationship	1	2	3	4	5
Concerned about being sexually harassed	1	2	3	4	5
Am sexually inappropriate with others	1	2	3	4	5
Afraid of losing someone I love	1	2	3	4	5
Concerned about someone else's sexual behavior	1	2	3	4	5
Interpersonal conflicts	1	2	3	4	5
Worry about what others think of me	1	2	3	4	5
Overly concerned about personal appearance	1	2	3	4	5
Unable to control my anger	1	2	3	4	5

Physical Health Issues

Feeling stressed	1	2	3	4	5
Nightmares/Restless sleep	1	2	3	4	5

Appetite Loss	1	2	3	4	5
Frequent headaches	1	2	3	4	5
Chronic or frequent illness	1	2	3	4	5
Weight concerns	1	2	3	4	5
Alcohol/Drug abuse	1	2	3	4	5
Lack of exercise	1	2	3	4	5
Too much energy	1	2	3	4	5
Under-eating	1	2	3	4	5
Overeating	1	2	3	4	5
Binging and purging	1	2	3	4	5
Concerns about sexually transmitted diseases	1	2	3	4	5
Concerns about Pregnancy	1	2	3	4	5

Emotional Health

Feeling sad often and for long periods	1	2	3	4	5
Feeling irritable	1	2	3	4	5
Angry outburst or prolonged anger	1	2	3	4	5
Feeling anxious	1	2	3	4	5
Extreme mood swings	1	2	3	4	5
Crying easily and often	1	2	3	4	5
Feeling depressed for long periods	1	2	3	4	5
Trust issues	1	2	3	4	5
Suicidal thoughts	1	2	3	4	5
Have attempted suicide	1	2	3	4	5

Family Issues

Being criticized by my parents	1	2	3	4	5
Parent expectations of me too high	1	2	3	4	5
Parent's divorce/separation problematic	1	2	3	4	5
Concerned about behavior of relatives, friends, or acquaintances	1	2	3	4	5
Sexual inappropriateness by family member(s)	1	2	3	4	5
My parents try to control me	1	2	3	4	5
Illness in family	1	2	3	4	5
Bothered by events of the past	1	2	3	4	5
Family non-supportive of my life choices	1	2	3	4	5
Concern about current family issues	1	2	3	4	5
Afraid of getting close to people	1	2	3	4	5
Sexual problems in relationship	1	2	3	4	5

Thank you for answering these questions. This will help me to know how to help you. Feel free to address any or all of these issues with me as you feel comfortable. You can ask me anything or talk to me about anything!

***Sincerely,
Miriam Lieberman, MA, LPC***