Lisa Reid, LCSW
Essential Connections
COUNSELING & CONSULTING
12700 Century Drive, Unit E, Alpharetta, GA 30009
info@essentialconnections.net | 804-627-2365 (direct) | | www.essentialconnections.net

YOUTH INFORMATION FORM (Under Age 18)

This Form is Confidential

Today's date: _____ **Youth's Preferred Name:** _____

Youth's Legal Name: _____
Last First Middle Initial

Youth's Date of Birth: _____ **Gender assigned at Birth:** ☐ Male ☐ Female

Home Street Address: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: _____ **Work Phone:** _____

Best Contact Cell Phone: _____ **Email:** _____
Calls will be discreet, but please indicate any restrictions: _____
_____

Parent/Legal Guardian's Name: _____ **Cell Phone:** _____
Last First Middle Initial
Email: _____ **Name of Employer:** _____

Position/Field of Work: _____ **Highest Level of Education**: _____

Other Parent/Legal Guardian's Name: _____ **Cell Phone:** _____
Last First Middle Initial
Email: _____ **Name of Employer:** _____

Position/Field of Work: _____ **Highest Level of Education**: _____

How did you hear about Lisa Reid, LCSW/Essential Connections?: _____

Please briefly describe your presenting concern(s):_____
_____
_____
_____

What are your goals for therapy? _____
_____
_____

What are your parents' or caregivers' goals for therapy? _____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)?_____

Who is responsible for session payments? _____

MEDICAL HISTORY: (if you need more room, please write on the back of this page)

Please explain any significant medical problems, symptoms, or illnesses you have had:_____
_____
_____

When were you last seen for a full physical/medical evaluation? _____/_____/_____

Name of PCP or Pediatrician: _____ Phone: _____

Current Medications: (if you need more room, please write on the back of this page)

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Previous medical hospitalizations (Approximate dates and reasons): _____
_____
_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____
_____

Has you ever talked with a psychiatrist, psychologist, or other mental health professional? □ Yes □ No If yes, please list approximate dates and reasons: _____
_____
_____

Youth's Sexual & Gender Identity: __ Heterosexual __Lesbian __ Gay __ Bisexual __Transgender __ Asexual
__ In Question __ Other: _____

Youth's Racial/Ethnic Identity:
__ African/African-American/Black
__ American Indian/Alaska Native
__ White/European-American
__ Bi-Racial/Multi-Racial
__ Latino/Latino-American
__ Middle Eastern/Middle Eastern-American
__ Asian/Asian-American/Asian Pacific Islander
__ Not listed, Other: _____

FAMILY:

How would you describe your relationship with your mother?_____
_____
_____

How would you describe your relationship with your father?_____

_____
_____

Are your parents still married? □ Yes □ No Separated? □ Yes □ No Divorced? □ Yes □ No

If they divorced or separated, how old were you when your parents separated or divorced? _____years old

How do you think this has impacted you? _____
_____

Were there any other primary care givers who have had a significant relationship with you? If so, please describe how these people may have impacted your life: _____
_____
_____

Do you have any siblings? □ Yes □ No, If yes, indicate each sibling's name, age and where he/she lives if not with family: _____
_____
_____

If applicable, describe your relationships with each of your siblings?_____
_____
_____
_____

Family History of (relating to parents, siblings, grandparents, or other close relatives-check all that apply):

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Legal Trouble			Sexual Abuse			Anxiety		
Drug/Alcohol Problems			Physical Abuse			Depression		
Domestic Violence			Hyperactivity			Psychiatric Hospitalizations		
Suicide			Learning Disabilities			"Nervous Breakdown"		
Police Involvement:			Inattention:			Other:		

Please briefly describe anything else about your family's history that you believe would be helpful for your therapist to know: _____
_____
_____
_____

SOCIAL SUPPORT, SELF-CARE, & EDUCATION:

Your current level of satisfaction with friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

How would you describe your relationships with your peers? _____
_____

Please briefly describe what you do for self-care and coping skills: _____

_____
_____

What are your nutritional habits and diet? _____
_____
_____

Please briefly describe your exercise and activity patterns? _____
_____

Please briefly describe your school performance and school experience:_____
_____
_____

Please briefly describe your earliest experiences learning to read: _____
_____

What are your hobbies, talents and interests?_____
_____
_____

What is your spiritual belief or religious background, if applicable? _____
_____

How would you describe your intimate relationship experience?_____
_____

What are your strengths?_____
_____
_____

PLEASE ***CHECK ALL THAT APPLY*** (TO YOUTH):

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Anxiety			Concentration			Separation Anxiety		
Depression			Headaches			Alcohol/Drugs		
Mood Changes			Loss of Memory			Vapes/Smokes		
Anger or Temper			Excessive Worry			Drinks Caffeine		
Panic			Wetting the Bed			Frequent Vomiting		
Fears			Trusting Others			Eating Problems		
Irritability			Communicating with Others			Severe Weight Gain		
Head Injury			Following Directions			Severe Weight Loss		

PLEASE ***CHECK ALL THAT APPLY*** (TO YOUTH):

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Tantrums			Issues re: Divorce/ Separation			Sleeping Too Little		
Parents Divorced			Sexually Acting Out			Getting to Sleep		
Seizures			History of Child Abuse			Waking Too Early		
Cries Easily			History of Sexual Abuse			Nightmares		
Problems with Friend(s)			Domestic Violence			Sleeping Alone		
Problems in School			Thoughts of Hurting Someone Else			Nausea		
Fear of Strangers			Thoughts of Suicide			Stomach Aches		
Fighting with Siblings			Sleeping Too Much			Fainting		

PLEASE ***CHECK ALL THAT APPLY*** TO YOUTH:

Difficulty with:	Now	Past	Difficulty with:	Now	Past	Difficulty with:	Now	Past
Concussion			Lump in the Throat			Often Makes Careless Mistakes		
Dizziness			Sweating			Fidgets Frequently		
Diarrhea			Heart Problems			Impulsive		
Shortness of Breath			Muscle Tension			Waiting His/ Her Turn		
Chest Pain			Bruises Easily			Completing Tasks		
Chills or Hot Flashes			Allergies			Paying Attention		
Clothing/ Textures			Hyperactivity			Easily Distracted by Noises		

PLEASE LOOK BACK OVER THE ABOVE 3 SECTIONS AND **CIRCLE** THE **MAIN PROBLEM**.

Any additional information you would like to provide (including any questions you wish had been asked that were not):

_____

_____

_____

_____

_____

Person(s) to notify in case of an EMERGENCY:

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

**Please be sure to complete a Release of Authorization for each person listed above.*

How honest have you been in completing this questionnaire: _____

List the Names of Persons who Helped to Complete These Forms:

Print Name(s)	Date
_____	_____
_____	
_____	
_____	

_____ Reviewed by Lisa Reid, LCSW, on _____
Initial Date