

Irons Counseling & Supervision
13625 Pond Springs Rd., Suite 105
Austin, Texas 78729

ADOLESCENT INFORMATION FORM
(To be completed by adolescent and guardian)

Date: ____/____/____ Therapist _____

Client name: _____ Preferred name / nickname: _____

Legal guardian name(s) and relation to client: _____

Date of birth: ____/____/____ Age: _____ Gender: _____

Client Phone: _____ Guardian Phone: _____

Ok to leave voice messages? Ok to text?

Client Email: _____

Guardian Email: _____

Address: _____

City: _____ State: _____ Zip: _____

School: _____ Grade: _____

Emergency contact person: _____ Relation to client: _____

Emergency contact number: _____

How did you/your family learn about this practice? _____

Please check any of the following emotions that describe how you've been feeling lately:

sad anxious depressed frightened guilty angry ashamed
aggressive resentful worthless tearful irritable confused extreme ups/
downs jealous hopeless helpless annoyed lonely insecure
embarrassed grieving hurt

other (list): _____

In your own words, what brings you to therapy at this point in time?

What would feeling "better" look like for you? Describe your goals for therapy:

Check the number that represents the current severity of your concerns:

(Not Severe) 1 2 3 4 5 (Very Severe)

Are you currently having suicidal thoughts? (if yes, describe)

Have you had previous suicidal thoughts or attempts? (if yes, describe)

Please list any medical conditions (past or present) that may be contributing to your situation:

List any medications you are taking and their purpose:

Have you ever been hospitalized for mental health issues? (if yes, describe and list dates)

Please describe any recreational drug and/or alcohol use, or tobacco use past or present (include frequency, amount & last use):

List and describe any previous counseling or psychiatric treatment you have received. Please list prior conditions, treatment(s), dates and from whom you received treatment:

Describe what was helpful and/or unhelpful from past therapy:

What other information would you like your therapist to know about you? (examples: important relationships; family dynamics and history; major life changes; hobbies/interests; etc.)

Guardian: In YOUR words, what does your adolescent need help with at this time?

Guardian: What would "better" look like for your adolescent? Describe your goals for therapy:

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____