

FAMILY CHRISTIAN COUNSELING
3035 N. W. 63RD street, Suite 101, Oklahoma City, OK 73116

Part I: Comprehensive Adolescent Psychosocial/Treatment Plan
Confidential

Date: _____

Referred by: _____

CLIENT INFORMATION

NAME _____ GENDER: Male Female BIRTHDATE _____ AGE _____
 ADDRESS _____ HOME PHONE _____
 CITY _____ STATE _____ ZIP _____ CELL PHONE _____
 How long have you lived at this location? _____ yrs _____ mos Moved in the last 5 years? _____ Number of times _____

If someone other than the adolescent is providing this information, please indicate your relationship _____

Do you have a court appointed legal guardian or a conservator? Yes No - please complete the following information:

Name	Address	Phone Number(s)

CHECK THE PROBLEM(S) FOR WHICH YOU ARE SEEKING HELP Check all that apply

- crisis trauma behavior school isolated anger stress
- medical grief/loss DHS divorce step-family court DUI
- impulsive behaviors abuse sibling issues parent/child communication social skills
- boundaries mood swings problem solving skills rape/ sexual assault
- change in appetite/sleep patterns pornography difficulty making/keeping friends
- doesn't care about anything unable to cope with emotions overwhelming emotions
- sexual identity conflict excessive computer use unsafe use of computer
- thoughts of hurting self or someone else (suicidal/homicidal ideation/plan?)

IS THERE VIOLENCE IN THE HOME? No yes, type: mental physical emotional or verbal spiritual

CHECK ANY OF THESE EXPERIENCES THAT ARE PROBLEMATIC Check all that apply.

- IQ score if MR _____ Oriented to person, time, place
- conflict w/ mother conflict w/ father conflict w/ parent's partner conflict w/ siblings
- conflict w/ peers conflict w/ teachers conflict w/ other authority nightmares or disturbing dreams
- drug/alcohol use arrests/delinquency running away from home bed wetting
- excessive fear/worry depression sadness anorexia, bulimia, overweight
- stealing gang involvement excessive guilt low energy
- serious accident witness to serious fire impulse control negative self beliefs
- teen parent cruelty to animals significant losses-people, pets, etc.
- can't shut down thoughts afraid to be away from parents or home
- ideas of worthlessness suspicious of people or low trust
- difficulty making decisions difficulty concentrating
- believe other people cause my problems other, describe

Imagine things are real that aren't: imaginary playmate(s) as child auditory visual
 memory problems (short term long-term) hurricane, tornado, flood or other act of nature
 inappropriate sexual behavior has taken place around you or been directed at you, by whom?
 _____ (Name & Relationship) Your age at the time of exposure? _____

CONFLICT/ VIOLENCE/ TRAUMA ISSUES

Ever been threatened/ attacked/ afraid for safety/life No Yes
Ever targeted by a bully at school or work No Yes
Ever been target of racism/ discrimination No Yes

Experienced intimidation/ control No Yes
Ever been a target of gender violence No Yes
Home with chronic problems No Yes

Additional Comments:

OF THE PROBLEMS YOU'VE IDENTIFIED, WHAT IS THE MAIN PROBLEM THAT CAUSES YOU THE MOST DIFFICULTY?

HOW LONG HAS THIS BEEN A PROBLEM?

DESCRIBE THE YOUR POINT OF VIEW ON THE PROBLEM

WHAT IS THE MAIN PROBLEM, ACCORDING TO YOUR PARENT(S)/ CAREGIVER(S), THAT CAUSES YOU THE MOST DIFFICULTY?

DESCRIBE WHAT YOU AND YOUR PARENT(S)/ CAREGIVER(S) HAVE ALREADY TRIED TO SOLVE THE PROBLEM

How serious is this problem? Low 1 2 3 4 5 6 7 8 9 10 High
How hopeful are you that your life can be better? 1 2 3 4 5 6 7 8 9 10

DESCRIBE WHAT YOUR STRENGTHS ARE, THE THINGS YOU DO WELL

CHECK WHO OR WHAT YOU RELY ON FOR HELP OR NAME THE RELATIONSHIPS THAT ARE IMPORTANT TO YOU.

faith family friends teacher neighbors other, provide details below

DESCRIBE YOUR RELATIONSHIPS IN YOUR HOME:

DESCRIBE YOUR RELATIONSHIPS OUTSIDE OF YOUR HOME:

DESCRIBE WHAT YOU DO FOR RECREATION OR FUN OR LEISURE

DESCRIBE WHAT YOU WOULD LIKE TO BE DIFFERENT AS A RESULT OF COUNSELING

DESCRIBE WHAT YOUR PARENT(S)/ CAREGIVER(S) WOULD LIKE TO BE DIFFERENT AS A RESULT OF COUNSELING

How long do you think it will take to resolve the problem/s? 1-3 visits 2-3 months 6 months other
Additional Comments:

CHECK THE YOUR LIVING ARRANGEMENTS

- living with biological family living w/ adoptive family living w/ relatives living w/ friends
 foster care community shelter homeless institutional setting
 other, *please provide details*

Please list the individuals presently living in your home

Name	Age	Relationship to you

Please list any individuals who used to live in your home and now live somewhere else

Name	Age	Relationship to you	Reason They Live Elsewhere

DOES YOUR FAMILY HAVE ANY PROBLEMS WITH PROVIDING THE FOLLOWING FOR YOU OR OTHER FAMILY MEMBERS?

- No Yes, please check which one(s) & provide additional details below.
 hygiene food clothing shelter transportation medical/dental needs

Additional details:

- ETHNIC GROUP** Caucasian Black Alaskan Native Asian or Pacific Islander
 American Indian, tribe _____ Hispanic _____ Other _____

CULTURAL INFORMATION *Check all descriptors of who or what life events have had the greatest impact on you and/or your family*

- holidays chaotic family violence trauma disabilities addictions
 spirituality/ religion family traditions family culture friends neighbors scouting
 learning/ education school sports work social abuse
 foods lifestyle choices travel reading gender social status
 nontraditional roles or experiences community organizations other, *details in additional comments*

Additional Comments:

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NAME _____ BIRTH DATE _____ TODAY'S DATE: _____

EDUCATION

Name of your school _____ Current grade in school _____

Have you ever repeated a grade? No Yes, which one _____

Your attitude toward school? like it indifferent dislike it frequently absent

Grades are primarily _____ Learning disabilities/special classes _____

ARE YOU EMPLOYED? No Yes, please provide the following information

Occupation _____ Length of time on current job _____ # of hours/week _____

Problems on the job? No Yes, explain _____

Additional Comments:

DEVELOPMENTAL HISTORY (YOU MAY NEED TO CONSULT WITH YOUR PARENT(S)/ CAREGIVER(S) FOR THE FOLLOWING INFORMATION)

Place/ location of your birth _____

Was your birth: planned unplanned full-term premature, how much _____

Any complications during pregnancy or delivery? No Yes, provide details

Age of your mother at your birth? _____ Were you breastfed? No Yes

During pregnancy, did your mother use drugs alcohol other substances? No Yes, please provide details

Indicate approximate age when you reached the following developmental milestones:

Walking _____ Talking _____ Toilet training _____

PERSONAL HISTORY

You have been primarily raised by:

birth parents father & step-mother foster parents mother only father only mother & step-father

grandparents other relatives adoptive parents

List the names & ages of all siblings _____

Parents/ caretakers argue frequently? No Yes

If yes, is any physical violence involved? No Yes

Parents divorced? No Yes

Family experiences severe financial problems? No Yes

Anyone in the family ever earned money from illegal activities? No Yes

Is the family eligible for public assistance? No Yes

Anyone in family physically or sexually abused? No Yes, by whom?

Additional information:

HOW WOULD YOU DESCRIBE YOUR MOTHER (M) AND FATHER (F)? Check all that apply.

Warm M F Overprotective M F Domineering M F Affectionate M F

Uncaring M F Fault-finding M F Average M F Strict M F

Smothering M F Absent M F Understanding M F Rejecting M F

Distant M F Perfect M F Supportive M F Too little discipline M F

Alcohol/ drug dependent M F Behavioral addiction M F Depressed/ unhappy M F

PERSONAL RELIGIOUS INFORMATION: My spiritual beliefs are important in my life Yes No

I am involved in church / religion / spiritual practice. My church home is_____

I attend (Circle) Several Times/Week Weekly Monthly Sporadically Seldom Never

My family attends (Circle) Several Times/Week Weekly Monthly Sporadically Seldom Never

My religious background is_____. My parent's/ caregiver's religious background is_____.

Describe any significant religious experiences.

Describe any unexplainable experiences.

I have made the discovery of knowing Jesus Christ personally. Yes No Tell about your experience:

I am satisfied with my personal faith. Yes No

Additional Comments:

MEDICAL/ PHYSICAL/ MENTAL HEALTH HISTORY

Your current level of health: Excellent Good Fair Poor

Check any of the following that apply: agitation posture problems tics/tremors walking difficulties repetitive acts

I am: underweight appropriate overweight, by how many pounds_____

To the best of your knowledge, does anyone in your family experience: depression bipolar schizophrenia
Who? mother father sibling other family member—Who?_____

Are you currently being treated anywhere else? No Yes
Have you had previous EAP/mental health services? No Yes
Have you ever been hospitalized for mental health problems? No Yes, *Please provide details for any yes answer below*

OPI/ EAP Therapist or Hosp. / Dr./ City	Dates of Service	Reasons for service

Please list your personal physician or psychiatrist. FCC **will not** contact your personal physician or psychiatrist without your parent's/guardian's written consent to do so. We maintain this information in the event of a medical emergency.

Name	Address	Phone #	Date last seen

Please list the prescription & non-prescription medications, including vitamins, you are presently taking and those you have taken in the past 6 months:

Drug Name	Dose	Frequency	Prescribing Physician	Length of time on Drug	Benefits	Side Effects

Are you allergic to any foods or medications? No Yes, please provide details

Check any symptoms you are currently experiencing:

- fatigue bloody sputum cough lasting more than 2 weeks sudden weight loss/gain loss of appetite
 weakness chills night sweats fever chronic health problem, provide details below

Does your health impact or limit your daily functioning in any way? No Yes, provide details below.

Details to any question answered yes or any other additional comments:

Do you now have or have you ever had:

- | | | | | | |
|---|-----------------------------|------------------------------|----------------------------|-----------------------------|--|
| Eye problems, need glasses, increased pressure in eyes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hearing problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Fainting spells, black-outs, falling, dizzy spells? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Severe headaches? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Not able to move a part of your body? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Goiter, thyroid problem? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Hands, feet or ankles that swell up? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Pains in your chest? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Kidney trouble, trouble passing urine? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Abnormal thirst or hunger? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Decreased interest in sexual activity? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Stomach trouble or ulcers? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Liver disease, skin or eyes turn yellow? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Sleeping problems? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Any recent change in your appetite or eating habits? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Trouble with constipation or diarrhea? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Surgery? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, date(s)/type(s)_____ |

Please check any that apply to you now or in the past:

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> measles | <input type="checkbox"/> polio | <input type="checkbox"/> German measles | <input type="checkbox"/> meningitis | <input type="checkbox"/> mumps |
| <input type="checkbox"/> diphtheria | <input type="checkbox"/> lupus | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> pneumonia | <input type="checkbox"/> glaucoma |
| <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> skin problems/diseases | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes | <input type="checkbox"/> heart problems |
| <input type="checkbox"/> bleeding ulcers | <input type="checkbox"/> mononucleosis | <input type="checkbox"/> blood clots | <input type="checkbox"/> anemia | <input type="checkbox"/> epilepsy/seizures |
| <input type="checkbox"/> gonorrhea | <input type="checkbox"/> food poisoning | <input type="checkbox"/> syphilis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> broken bones | <input type="checkbox"/> concussions | <input type="checkbox"/> knocked unconscious | |
| <input type="checkbox"/> dislocations | <input type="checkbox"/> wounds | <input type="checkbox"/> head injuries | <input type="checkbox"/> chemical/drug poisoning | |
| <input type="checkbox"/> positive TB test | <input type="checkbox"/> cancer/ type_____ | | age_____ | |

DO YOU HAVE ANY LEGAL ISSUES PENDING?

- | | | | | |
|-----------------------------|------------------------------|------------------------------|-------------------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | | | |
| Ever been arrested? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Been in jail or juvenile detention? | |
| On probation or parole? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Current DHS/ Court involvement? | |
| Legal/ criminal record? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

If yes to any of the above, please provide details?

Will your parent/guardian want a letter sent to any of the following on your behalf? No Yes, then complete:

	Name	Phone #	Details
DHS Caseworker			
Judge			
Parole/probation officer			
Lawyer			

SUBSTANCE/ BEHAVIORAL ADDICTION HISTORY Family has a history of addictions No Yes
 If yes, who? grandfather grandmother father mother sibling other relatives
 My parents are concerned about my use of substances or addictive behaviors

Substance or Behavior	What and/or how much	Age of 1 st Use	Age of last use or still using	Rt of administration: oral, nasal, smoking, injection, other	Received treatment &/ or attending 12 Step Group
Alcohol					
Drugs					
Prescription Meds					
Tobacco					
Caffeine (incl tea, sodas)					
Gambling					
Excessive Computer use					
*Sex					
**Codependency					
***Food issues					

* sex-includes pornography, several partners, etc

** codependency (focusing on others' behaviors, generally putting others first, feeling used & taken for granted)

*** food (includes excessive sugar, salt, junk foods, overweight, anorexia, bulimia)

I have received treatment for addictions. Please provide details.

Males –experienced any gender specific health problems? no yes, please explain

Females Age at time of first menstrual period: _____ Flow: Light Average Heavy
 Is your menstrual cycle regular? No yes Avg # of days? _____
 Are you now pregnant? No yes Hit while pregnant? No yes
 Pregnancy history: Total # of pregnancies _____ # of premature births _____
 # of c-section deliveries _____ # of stillbirths _____
 # of miscarriages _____ # of surgical abortions _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY: fluent in English fluent in (other language) _____
 English Second Language hearing impaired need interpreter use signs speech impaired fluency issues

X _____
 Adolescent's Signature Date

X _____
Parent/Guardian's signature Date

X _____
Signature of Staff Person Completing Intake Date

DBN/4-1-2007