ASAP COUNSELING SERVICES

2440 Texas Parkway, Suite 250
Missouri City, TX 77489
O | (281) 969-7085
C | (713) 899-7982
asapcounseling_1@yahoo.com
www.asapcounselingservices.com

CHILDREN & TEEN PERSONAL DATA INVENTORY

Date Completed:
Dates Revised:

All questions contained in this questionnaire are strictly confidential and will only be shared with your counselor.

CLIENT DEMOGRAPHIC INFORMATION:					
Client Name *(Last, First.):*			☐ M ☐ F	**DOB:**	
Guardian Name:					
Relationship to Client:					
Address: *(City, ST, ZIP):*					
Phone		**Email:**			
How did you hear about ASAP Counseling Services:					
Grade:		**School:**			
Emergency Contact Information (Someone other than the person bringing child/teen to counseling)					
Name:	Phone:	Address:			
Presenting Problem (why is your child/teen here):					

Attempted Solutions & Results:	
Goal(s) for Counseling:	
Strengths:	
Hobbies/Interests:	
Family Structure Information	
Guardian Name #1:	
Guardian Name #2:	
Siblings:	

Please turn to next page

Children and Teen Personal Data Inventory (Page 2)

Who lives in the home with the child/teen?	
Who makes up the child/teen's support system?	
Do you believe this support system is adequate?	☐ **Yes** ☐ **No**
Why is this support system adequate ***(if you checked Yes)*****?**	**Why is this support system** **not** **adequate** ***(if you checked No)*****?**
How important is faith and belief in God to your family?	
What does your family believe about the following:	
God	
Jesus	
Holy Spirit	
What sin does your child/teen deal with regularly and how does it show up in their life?	
Church Affiliation:	
Pastor's Name:	
Counseling History	
Has your child/teen been in counseling previously?	☐ **Yes** ☐ **No**
If yes, please provide:	
Reason:	
Agency:	
Counselor Name:	
Counselor Phone:	
Permission to contact counselor:	☐ **Yes** ☐ **No**
Current Medications your child/teen is taking:	
Medication Name	Purpose

Please turn to next page

CHILDREN AND TEEN PERSONAL DATA INVENTORY

Past Psychiatric History (if applicable)	
List any admissions or outpatient therapy:	
Diagnoses:	
Medications used/effectiveness:	
Family history of mental illness:	
Family history of suicide:	

Problem areas/areas of concern (Emotional):	*(check all appropriate answers in each category)*	
☐ Sadness	☐ Anger	☐ Guilt
☐ Fear	☐ Denial/Shock	☐ Panic
☐ Loneliness	☐ Hopelessness	☐ Separation Anxiety
☐ Apparent Lack of Feelings	☐ Other: ____________________	
Problem areas/areas of concern (Behavioral):		
☐ Regression	☐ Withdrawn	☐ Clinging Behavior
☐ Bad Language	☐ Violence	☐ Disruptive at Home or School
☐ Skipping School	☐ Absence from School	☐ Overly Tired/Sleepy
☐ Behavior "Too Good"	☐ "Man of the House" Attitude	☐ "Woman of the House" Attitude
☐ Giving Away Belongings	☐ Other: ____________________	
Problem areas/areas of concern (Cognitive):		
☐ Preoccupation with Death or Illness	☐ Confusion	☐ Daydreaming
☐ Homework Troubles	☐ Inattentive in Class	☐ Lack of Concentration
☐ Change in Academic Performance	☐ Suicidal Thoughts	☐ Thoughts of Hurting Others
☐ Other: ____________________		
Problem areas/areas of concern (Social):		
☐ Changes in Relationships with Parents	☐ Changes in Relationships with Siblings	
☐ Changes in Relationships with Friends	☐ Lack of Support System	
☐ Other: ____________________		
Problem areas/areas of concern (Physical):		
☐ Eating Problems	☐ Sleeping Problems	
☐ Somatic Complaints *(pain, digestive issues, hormonal imbalances, immune system dysfunction, medical issues, depression, anxiety and addiction)*	☐ Other: ____________________	