STUDENT INFORMATION

Date: _____

Patient's Information:

Parents Name: _____ Phone: _____

Address: _____

Employment: _____ Phone: _____

Birth Certificate for child ____ Valid Custody Papers ____ DHS Custody ____

Legal Guardian: _____

Legal issues pending ____ yes ____ no If Yes, explain: _____

Student's Information:

Name: _____ Age: _____ Date of Birth: _____

Address: _____

Phone: _____

Social Security (for insurance purposes): _____

School History:

Current School: _____ Grade: _____

What kind of grade's? A B C D F Incomplete

What do the teachers say?

Has the student ever repeated a grade? _____ Which one? _____

Suspensions, expulsions, detentions? _____

School Behavior: _____

Special Ed? _____

Physical condition: poor fair average good
Emotional condition: poor fair average good
Spiritual condition: poor fair average good

Circle the words that describe why you need counseling:

Addiction	Loss of faith	Friend Problems	Sexual Concerns
Anger	Loss of hope	Guilt	Someone I love died
Anxiety	Loss of faith in others	Sad a lot of time	Someone I love left me
Cutting	Loss of meaning	I hurt myself	Loss of faith in myself
Family Problems	Loneliness	Nerves/Nervousness	Other: _____

Parent/Guardian Signature: _____ Date: _____

Student's Signature: _____ Date: _____

MENTAL STATUS EXAM

Appearance: ____ Well Groomed ____ Dirty/Dishevel ____Obese ____Average ____Slim

Behavior: ____ Appropriate ____ Dependent ____ Resistant ____ Cooperate ____ Sarcastic ____ Guarded

Motor Activity: ____ Non-remarkable ____Tremulous _____Restless ____Slurred Speech ____Agitated

Mood/Affect: ____ Normal ____ Anxious ____ Sad/Depressed ____ Angry ____ Labile ____ Flat/Blunted ____ Guarded ____ Irritable ____ Other

Thought Content: ____ Realistic/Oriented ____ Disorganized ____ Flight of ideas ____ Delusional ____ Paranoid ____ Obsessions ____ Hallucinations (Auditory, Visual, Tactile, Olfactory)

Current Suicidal Thoughts? ____ yes ____ no If yes, how would you do it?_____

_____

History of Suicidal Behavior? ____ yes ____ no Specify (thoughts, plans, gestures or attempts):

_____

Current Homicidal Thoughts? ____ yes ____ no If yes, explain. _____

History of Homicidal Behavior? ____ yes ____ no (Assaultive thoughts, plans, gestures or attempts):

_____

Violent Behavior (recent or remote) _____

Have you ever been a victim of abuse, sexual or physical? ____ yes ____ no

_____

Family history of psychiatric/chemical dependency problems? ____ yes ____ no

_____

Has any family member ever attempted suicide? ____ yes ____ no (who, when, how)

_____

CHEMICAL DEPENDENCY

Use of.... Yes/No	How Much	Last Use
Alcohol		
Tobacco		
Sedatives/Tranquilizers: Xanax, Valium, etc		
Stimulants: Speed, diet pills		
Sleeping Pills		
Opioids: Demerol, Lortab, Percodan, Codeine		
Marijuana		
Hallucinogens: LSD, PCP		
Heroin/Methadone		
Cocaine/Crack/Base		
Inhalants: glue, gas, paint		
XTC		

Withdrawal Symptoms: _____

Significant Periods of Sobriety: _____

Current Medical Problems: _____

Current Medications: _____

Primary Care Physical: _____

Recommendations: _____

Application Form Completed by: _____