Andover Wellness and Counseling
853 Turnpike Street 2nd Floor
North Andover, MA 01845
Phone: 978-417-1531
Email: papadinis.rebecca@gmail.com

Teen Anxiety and Self-Esteem Group

This form may seem long, but the information on it will help me to better understand you. The information on this form is confidential unless it has to do with hurting yourself or someone else.

Adolescent Demographic Information

Name:_____

Address:_____

Gender:_____ Age: _____ Date of Birth: _____

Home phone:_____ Is it okay to leave a message: yes/no (please circle one)

Client Cell Phone: _____ Is it okay to leave a message: yes/no (please circle one)

Parent Cell Phone:_____ Is it okay to leave a message: yes/no (please circle one)

Parents or Legal Guardians: _____

With whom do you live? _____

How did you hear about the group? _____

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What school do you attend? _____ Grade: _____

Do you like attending this school? Are you have any difficulties? If so briefly explain.

_____

_____

What are your interests or hobbies?

_____

_____

Assessment:
Please check any/all of the symptoms that you are having

Depression		Feeling hopeless	
Extreme sadness		Problems getting along with family	
Trouble concentrating		Change in sleeping habits	
Memory Problems		Lack of energy	
Change in eating habits		Weight changes	
Extreme happiness		Feeling tearful	
Trouble going to school		Problems getting along with friends	
Lack of enjoyment in usual activities		Feeling stressed	
Obsessions/Compulsions		Feeling worried or anxious	
Easily irritated		Feeling fearful	
Feeling Guilty		Physical complaints of pain	
Problems with anger		Sudden feelings of panic	
Unusual dreams		Muscle tension	
Drug or alcohol use		Acting violent	
Thoughts of hurting yourself or others		Thoughts of killing yourself or others	
History of self-harming behavior		Active self-harming behavior	

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Do you currently see a therapist? (Yes/No) If so, what is their name?

_____

Have you been diagnosed with a mental health disorder? If so, which one(s)?

_____

History:

Have you ever experience any critical events or an event that you consider traumatic?

_____

_____

If so have you sought help for this, or does it continue to cause you distress at this time?

_____

Expectations:

What would you like to get out of this group?

_____

_____

What else would you like for me to know at this time?

_____

_____

_____

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Parents:

Please feel free to add anything you wish below (additional information you would like me to know, goals, concerns etc.)

_____

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this form. This information will be very helpful to me so as I can best support you/your teen.